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SURGERY

Diseases of the Scrotum and Contents

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I was asked by the committee to discuss a Urological subject of interest to the general surgeon. Obviously this removes from consideration a group of topics which are of decided interest only to the Urologist. I should like to discuss diseases of the scrotum and contents, a topic which I hope will be of interest, and one that certainly comes under the scrutiny of everyone. Time obviously does not permit of a full discussion. For the sake of brevity, I will mention only the more common diseases outside the field of neoplastic growths of the testicle that will be discussed in more detail later. The anatomic sequence of discussion will be the skin, vas deferens, the spermatic cord, epididymis, and testes.

Injuries of the scrotum are seldom of major importance. Even with the complete evulsion of the skin the regenerative power of the scrotum makes repair and plastic surgery a comparatively simple matter. Penetrating injuries may lead to hematoma and necessitate surgical intervention. Edema is frequently seen, but is usually a secondary to cardiac and renal failure. Edema due to inguinal adenitis with blockage of the lymphatics is not often seen, and is frequently misdiagnosed as pseudoelephantiasis. Infection of the scrotum is rarely noted, and is usually secondary to skin lesions or tuberculous lesions of the epididymis. Urinary extravasation with secondary fistula due to stricture of the urethra is still seen, but much more rarely than fifteen years ago. The scrotum is tense, bluish-red, and extremely painful, and unless early excision and drainage is accomplished gangrene will follow. Elephantiasis is practically unknown in the temperate zones and merits no discussion at this time. Pseudo-elephantiasis is probably due to a lymphadenitis. It has been reported following the removal of inguinal glands, or even following herniotomy.

Tumors of the scrotum proper are rare. Kretchmer[1], of Chicago, reported a case of pure fibroma of the scrotum in 1946, but was unable to find any other pure fibroma reported up to that time. I had one case of myxofibroma weighing 1250 grams on my service two years ago which proved to be benign. Carcinoma is rarely seen in this country. Dean[2] reported on twenty-seven patients seen in his service in New York, which extended over a period of twenty-one years. This is the largest single group reported in the U.S. that I have been able to find in the literature. He was able to establish a definite history in all but five of contact with coal tar products; of the five, no carcinogenic factor was found. These tumors are usually found on the most dependent part of the scrotum in the form of a small wart-like lesion if seen early, which goes on to comparatively early ulceration, at which time some pain may be experienced. Squamous cell carcinoma is most generally the histologic pattern. Treatment is surgical, with wide excision and removal of the involved inguinal glands. While this lesion should be discovered early by the patient, unfortunately it is usually in the form of an ulcer with metastasis before consultation is sought, and it generally gives a bad prognosis.

Infections of the vas deferens are secondary usually to infections of the seminal vesicles, although they can be involved occasionally with spread from a tuberculous epididymitis. Strictures of the vas are not uncommon and are usually in the scrotal portion. If complete, they are a cause of sterility, and are usually the result of gonorrhea. I have had no personal experience with anastomosis or plastic surgery. It is my belief that most of them fail in their goal. Tumors of the vas are extremely rare. Fibroma has been rarely seen, and sarcoma has been variously reported in very small numbers.

The spermatic cord does not frequently present pathological conditions of great importance, with the rare exception of a malignant tumor. Tumors of the cord are rare ... 87% of them are benign. Of the malignant tumors, sarcoma and endothelioma are most commonly found. Lipomas and fibromas make up the main number of benign tumors. Thompson[3] reported on twenty-six, of which twenty-one were lipomas and only two sarcomas. Torsion is a comparatively uncommon finding, but it is one of marked importance and should be dealt with without procrastination. Approximately 30% of all torsions of the cord are associated with undescended testicle or an abnormally motile testicle due to a long mesorchium. Symptoms are usually severe and sudden in onset; pain, swelling, tenderness, and followed by obvious inflammation. General systemic reactions of nausea, vomiting, with fever and chills, follow in rapid succession. The presence of hernia and hydrocele frequently com-

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plicate the diagnosis and it is most frequently misdiagnosed as strangulated hernia or epididymitis. Torsion falls in a great majority of cases between the ages of 15 and 25, although it is not uncommon in early life. I have had one in the newborn. Inciting cause may be a violent strain, or it may initiate itself without any significant factor. If torsion is diagnosed correctly, it should be treated as a surgical emergency as gangrene of the testicle is inevitable if unrecognized within the first twelve hours. Varicocele is a tortuous mass which frequently disappears when patient is recumbent. The symptoms are more aggravating than serious, consisting of the dragging sensation in the scrotum or a low grade pain in the groin. They usually respond satisfactorily to support, but a small percentage have symptoms disagreeable enough to indicate surgical interference. They are most frequently found on the left side, probably due to the left spermatic vein emptying into the renal vein encouraging valvular incontinence. Surgical procedure of choice is ligation at the internal inguinal ring, with excision of the internal spermatic vein. Hydrocele of the cord lies outside the tunica vaginalis. Diagnosis is usually not difficult, and it will transilluminate if the wall has not become too thick. Usually one can palpate both the upper and lower poles of the cyst which is diagnostic.

Lesions of the epididymis of clinical importance are usually the result of either trauma or infection. Spermatoceles, since they usually present no symptoms, rarely need surgical intervention. Epididymitis of gonorrheal origin is now rarely observed due to the advent of chemotherapy. The most common form of epididymitis at present is the type following transurethral resection of the prostate. The incidence as reported from various clinics runs from six to ten per cent. One year ago I thought it advisable to go back to bilateral vasectomy. Since then I have had no cases of epididymitis following transurethral resection. This is in distinct contradiction to reports of Nesbitt[4] and Flocks[5]. It is their belief, following a study of a large number of cases, that the morbidity is about the same as determined by control groups. There is no doubt in my mind, however, that I will have occasion to find them, as frequently these patients are already infected from previous catheterizations.

Infection of non-tuberculous origin is largely secondary to the infection of the seminal vesicles which has spread by direct extension along the vas deferens. This, in turn, is usually due to prostatic and urethral infections. Acute non-specific epididymitis usually follows the same pattern that we used to see with gonorrheal origin, ushered in with severe pain, chills, fever, severe systemic reactions in the form of nausea and vomiting, and even prostration in the aged. Usually the condition responds quickly to hot packs, support, and chemotherapy. However, many of these elderly patients in the prostatic group, go on to abscess formation despite adequate therapy.

Tuberculous epididymitis is usually insidious in its onset. It is considered by most men to be the primary lesion when there is a generalized infection of the genitals. The greatest number of cases are found between the ages of twenty and forty, although there are many seen in early childhood; and unquestionably many more are missed. It is considered hematogenous. According to the reports in the literature, in approximately 50% of these cases, there are no demonstrable lesions in the lungs, joints or kidneys. It is my personal belief, however, that these renal lesions run much higher, even though they have not been demonstrated. The patient that is hospitalized in a sanatorium, under observation for a greater length of time, is much more amenable to observation in this type of case; and subclinical lesions of the kidney often may be demonstrated by repeated guinea pig inoculations. The casual case even in the clinic or office, or in a hospital examination, frequently fails to reveal a lesion of subclinical type, either through culture or X-ray examination. However, unless there are other tuberculous lesions, which make hospitalization a necessity, it is often impractical to prolong observation. That may be the reason for the low percentage of other foci reported elsewhere in the literature. Acute tuberculous epididymitis can simulate a non-specific or gonorrheal epididymitis in every respect. This is probably due to the fact that it is a mixed infection. In making a diagnosis, the history of tuberculosis elsewhere in the body is important but frequently negative. One can ordinarily palpate a small, hard, smooth nodule in the tail of the epididymis. Usually, there is little difficulty in distinguishing the infected epididymis from the testicle, unless there is a secondary hydrocele. Draining sinus, or a history of a previous draining sinus, should direct attention to the tuberculous nature of the infection. Neoplasms and luetic lesions, must be ruled out but only rarely afford any difficulty. Careful search, once a diagnosis is made, for the lesions in the kidney, joints, lungs, should be made. Treatment is somewhat controversial. I do not believe any form of treatment can be recommended as 100% as each case treated is an individual. Epididymectomy is not without danger, as it frequently stirs up a miliary tuberculosis. Since the advent of dihydro-streptomycin and paramino salicylic acid this has been cut to a minimum. Certainly one can save a great deal of time if an early lesion is discovered, and epididymectomy is performed. This should be done in conjunction with the chemotherapy, and in my opinion the patient should be hospitalized for some time. The time element is, I believe, the only advantage of

surgery over the medical regime. At the local sanatorium I have been privileged to follow a few of these cases during the last several years, through the courtesy of Dr. Sandell. During this time, there has been no surgical intervention, largely due to lesions elsewhere which contra-indicated the surgery. Streptomycin has less value if caseation has already taken place, and there is liquidification and sinus formation. However, these patients have been given routinely one gram of dihydro-streptomycin daily in one dose, and three grams of paramino salicylic acid, four times daily, for 120 days, and without exception have responded well and the sinuses healed. Surgery will be given consideration again in some instances when the other lesions have come under control. In contradiction to reports elsewhere, we have found that 90% of all cases had renal involvement, many of them subclinical; but we were able to demonstrate tubercule bacilli in the urine through repeated guinea pig inoculation and culture. With many of these cases it took repeated urine studies before finding the organisms. This is also the experience of Lloyd[6] of Chicago, who for years has stressed repeated studies for suspected cases. A combination of chemotherapy and surgery would be indicated if the lesion is discovered before liquidification and sinus formation or if long hospitalization is not practical. Traumatic epididymitis can frequently be an important medical legal problem, because of the frequent claims for industrial injuries. The prostate and urethra and seminal vesicles should be closely checked in order to rule out lesions which might be responsible and in order to gain an equitable and honest diagnosis.

Infection of the testes are usually secondary to some systemic infections such as syphilis, typhoid, influenza, undulant fever, or mumps, and need no special discussion.

Undescended testicle, which fails to respond to endocrine therapy, should be surgically treated. Reports vary from 25 to 35 per cent successful treatment following endocrine therapy. My own personal experience has been considerably less than that. Certainly in these cases where there is a shortened spermatic cord, no success can be expected from endocrine therapy. Surgery when indicated, should be done about the seventh or eighth year to obtain the best results, using any surgical technique to which the surgeon has been accustomed.

Trauma, in the main part, while disagreeable and painful, does not present a serious picture. Few injuries are met with which necessitate surgical intervention, and they are usually the result of severe penetrating trauma, or torsion of the cord.

The incidents of malignant neoplasms would show it to be a comparatively rare lesion, the percentage of which varies considerably in different clinics. Hinman[7] and Smith reported incidents of 0.47% ,while Dean in his group found they constituted 2.09%. However, later reports on neoplasms in the army showed a much larger percentage and were reported as comprising 7.2% on all malignant neoplasms in the male.

Between ninety-tive and ninety-seven per cent of all tumors of the testicle are malignant. Indeed there are many pathologists who take the view that all tumors which are rated as benign are potentially malignant and should be treated as such. Benign tumors follow the same pattern as benign tumors elsewhere, and are usually found to be simple dermoids or benign teratomas. Benign tumors are thought to be hyperplasia of the interstitial cells of the testicle. Warren[9] and Olshausen in 1943 were able to find only twelve cases of benign neoplasms of the testicle, mostly occurring below the age of forty. In addition they reported on three interstitial cell carcinoma.

Classification of tumors of the testicle at present is in a state of confusion. I certainly would not presume to add to that state of confusion by attempting to clarify the situation. Probably one could discuss for several hours the various elaborate classifications of malignant neoplasms which have appeared in the recent literature by pathologists and urologists. Chevassu[10] in 1906 divided all neoplasms of the testicle roughly into two parts, one of which he felt consisted of teratomas and the second of an homologous type of tumor which he considered to be an anaplastic neoplasm originating in the germinal epithelium. To this tumor he gave the name seminoma. In 1911, however, Ewing[11] stated that he felt practically all testicular tumors were of teratomatous origin, that they arose from misplaced primordial totipotent germ cells in the region of the rete testes. Friedman [12] and Moore reported a series of 922 cases of tumor of the testicle occurring in males in the United States army. Their classification was as follows: Seminomas amounting to thirty-five per cent; Embryonal carcinoma, nineteen per cent; Teratoma, seven per cent, and Teratocarcinoma thirty-five per cent. The remaining four per cent were made up of one per cent interstitial cell tumors and the remainder falling into a mixed and unclassified group. Hurley divided their tumors into two main types on an entirely histological basis. He retained the name seminoma for the monocellular neoplasm. The term teratoma is used by him to designate a tumor arising from the cell which has the capacity to form a structure normally derived from the three embryonic germ layers. Under this he created two sub types, one of which is characterized by the presence of neoplastic structures representing two or more germ layers. The second, or the monodermal variety, is characterized by a type of tumor tissue foreign to the testes. The presence of this

tissue is best explained by regarding it as a one-sided neoplasia of the cell with totipotential capacities. The artificial sub-division of teratoma into benign and malignant or cancerous form has been retained in his report. He has found many tumors benign that were judged by microscopic pattern to be clinically malignant, and this has been found by many other reviewers. Hurley found, as many others have, that the teratoma and seminoma may be noted side by side or mixed with each other in the same tumor mass. The third type, and it is extremely rare, is an interstitial cell tumor, and he frequently found the epididymis to be involved in the neoplastic mass. The spermatic cord and the parietal tunics in the scrotum are very rarely invaded.

Rosenblatt[13] classified their 29 tumors as follows: Hemologous tumors, embryono-carcinoma, (seminoma), of which there were 20; and heterologous tumors, that were sub-divided as, (1) adult teratoma, of which there was one; (2) teratoma with malignant changes, six; (3) chorioepithelioma, two. They could find no histological difference between the embryona carcinoma as described by Ewing nor the seminoma as described by Chevassu.

For the clinician working without the benefit of highly geared research departments in teaching institutions, I believe it is better to discuss the simplest classification that will still dictate the proper diagnosis, treatment, and prognosis. I believe that Rosenblatts' classification serves that purpose admirably. Seminoma or embryonal carcinoma is the type of tumor most frequently found and affords the best prognosis. Seminomas usually fall in the age group between twenty to forty, with an average of thirty-five; while the teratomas average out twenty-eight years of age.

Trauma has long been a controversial question regarding etiology, and has frequently been a medical legal problem. It is the opinion of most of the investigators that trauma plays little if any part but merely directs the attention to pre-existing pathology. Lewis, quoted by Wesson[14], reported a case in which a man sustained a masserating injury to the testicle necessitating immediate orchiectomy. The pathologists examination revealed the presence of a small teratomatous neoplasm. It is quite possible that the association of trauma would have become an important factor had the presence of the tumor been discovered some time following the injury.

The diagnosis of neoplasms can be complicated and completely missed by secondary hydrocele. If uncomplicated, a painless, smooth, and ovade mass which is freely movable is usually the presenting symptom. If not noted for some time, pain may be the first symptom directing the patient's attention to the lesion. One would expect tumors to be diagnosed early because of their accessibility, but in civilian practice one frequently gets a history of several years' duration, and in a large series of cases the average time between onset and consultation was fifteen months. Lues and at time epididymitis may confuse the issue, but ordinarily can be ruled out with proper physical and laboratory examinations. With some of the teratomous type of tumors and particularly the chorioepithelioma, distant metastasis may be the cause of the initiating symptoms due to the spread to the retroperitoneal nodes or lungs. The tumors metastasize primarily by way of the lymphatic channels, which drained directly into the abdominal aortic nodes, which extend from the bifurcation of the aorta to the level of the renal veins. Enlargements of the retroperitoneal lymph nodes are responsible for the larger number of clinical manifestations, followed by a lesser degree of symptoms referable to the mediastinum or supraclavicular nodes. If inguinal adenopathy is noted, it is usually due to invasion of the parietal tunics and the scrotum itself, which is rare.

Attempts to correlate the various histologic types of tumors with quantitative levels of urinary gonadotropic output have failed. It is to be hoped that with more research along this line by various investigators eventually a more equitable classification of tumors will be possible through the correlation of histologic pattern and endocrine study. The Ascheim-Zondek test might be likened to the acid phosphatase test in carcinoma of the prostate inasmuch as a negative reading is of no significance. Lewis,[15] in reporting a series of cases, performed routine Ascheim-Zondek tests using normal controls. Thirty-five per cent of the controlled patients without tumors gave positive findings. Thirty-four per cent of the patients with seminoma who would not be expected to secrete gonodotropins, gave high readings. All of his patients with chorioepithelioma showed strongly positive readings. He therefore felt in the face of this evidence and in our present state of knowledge that the tests had little value either in diagnosis or prognosis.

The treatment of neoplasms is a widely disputed issue today, but all are agreed that seminoma can be treated with simple orchiectomy and deep X-ray therapy. Seminoma is a tumor of relatively slow growth and favors late metastasis which give it the best prognosis of all testicular malignancies. I think it advisable to ligate the important structures high at the internal ring and do a retrograde resection of the testicle. However, this is not, as it is considered by many, a true radical orchidectomy. Radical orchidectomy with excision of all retroperitoneal glands is definitely not indicated. Eight hundred to one thousand Roentgen ray units is considered an adequate dose. If a million volt machine is available, this can be given in a period of six to seven days, and with a 250,000 volt

machine, five to six weeks will be necessary.

In treatment of teratoid tumors, there are two distinct schools of thought. Lewis, Hinman, and others believe that radical orchidectomy should be done on all occasions in all types of tumor outside the field of seminomas. Chevassu himself recommended radical orchiectomy with resections of the retroperitoneal glands up to the level of the renal vein on the side of the tumor. Because of his results watched over a period of many years, he discontinued this practice some years ago. Certainly, if radical orchidectomy is to be considered, glands on both right and left side would have to be carefully resected in order to obtain results because of the anastomosis of the vessels at the bifurcation of the aorta. Lewis,[15] although a strong advocate for this radical surgery, admits that he has never been able to cure chorioepithelioma. Wesson, among others, has sighted cases of finding the metastasis on the left side with a primary on the right and vice versa. Lewis believes that in addition to the radical orchiectomy the patient should be given vigorous deep X-ray treatment varying from 3,000 to 6,000 r's, using the million volt machine. However, this is not without danger, and he reported fourteen of their patients treated in the excessive doses of 5,000 r's who developed within the next year and a half perforations of the bowel or stomach. Six of them recovered following surgical procedures, but the remaining eight died. There are probably more surgeons in the country today who feel that this extensive surgery is not justified by such results. It is their considered opinion that orchiectomy with ligation high at the internal ring followed by adequate maximal dosage of deep X-ray therapy will produce just as good a result and show as many five to ten year cures as those who have received the more radical therapy, and back this with results. In any event, tumors of the testicle do present a rather hopeless picture in our present state of knowledge, very much as do tumors of the bladder. No doubt a greater number of testicular tumors could be diagnosed much earlier if the patient presented himself upon noticing the lesion. Vermooten,[16] reporting on sixty-two cases in his service in the year 1941, analyzed the case histories and found that ten were accidentally discovered by the soldiers while they were bathing. Calisthenics and obstacle courses and other military training procedures drew the attention of eleven of the other soldiers to the presence of the swollen testes. Fourteen were discovered in routine examination by the medical officers, and only nine were discovered as an incident to trauma. In many instances the soldier admitted knowing that the testicle was enlarged and hard, but the condition had not bothered him and therefore had caused him no concern.

In this group one was diagnosed varicocele, seven as hydrocele, and five as traumatic orchitis. The larger group, fourteen in number, were incorrectly diagnosed as epididymitis, orchitis, or a combination of the two. Several others were qualified as tuberculosis. However, he added, despite the incorrect initial diagnosis, all of these patients were operated within four months from the time the lesion was first seen by the medical officers. In this series only fifteen showed evidence of metastasis when the patient was first admitted, and of these fifteen, two of them showed no evidence of primary lesion. Mewton stated that in his opinion this was due to the fact that the men received much earlier attention than the average lay citizen. Ferguson[17] cited Dean in an article as reporting five year cures in 29.2% of a series of 154 patients treated with X-ray alone.

Congenital tumors, tumors of the new-born or in childhood present no differences than those found in the adult. Campbell [14] was unable to find any reference to benign tumors of the new-born, but there have been many malignant neoplasms reported. The only difficulty in differential diagnosis is in ruling out hematocele which will give the same physical findings as a solid tumor. Hematocele is almost as rare in the new-born as is malignant tumor and can be diagnosed only through exploration. I had one benign teratoma on my service three years ago, and while the prognosis would seem to be excellent, in view of our present knowledge, I believe we should continue to give a guarded prognosis. To date the child has made normal progress. Treatment is the same as that of an adult.

In summary, a few of the more common diseases of the scrotum and contents were briefly mentioned and reviewed, there being no attempt to bring anything new or original into the discussion. A brief discussion of classification, diagnosis, and treatment of testicular tumors has been attempted and although elementary in scope I believe justifiable by the apparent confusion and many missed diagnoses as revealed in the current literature.

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MEDICINE

The Anaemias and Blood Transfusion

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Introduction

Anaemia is a sign encountered in almost every aspect of medical practice. It is a sign which is sometimes mistakenly regarded as a disease and accurate diagnosis is sometimes neglected. As a corollary, treatment is sometimes blind and often of a blunderbuss nature. Commercial advertisement and propaganda is notoriously effective in maintaining the illusion.

Increasingly blood transfusion is being used to "correct" anaemia and, while justifiable when truly indicated, the dangers associated with the giving of blood make it imperative that it should not be used when it is not essential. Above all, it must be realized that blood transfusion in a case of chronic anaemia is fraught with the especial danger of cardiac overload. Hunter[1] has clearly shown the strain which is borne by the enfeebled heart muscles in rapidly circulating a small volume of blood. Sudden increase in the circulating blood volume readily precipitates cardiac failure which, unless suitable steps are promptly taken, may prove fatal.

With greater availability of blood and plasma, with more elaborate technical precautions in grouping and cross-matching and with increasing realization of the importance of avoiding errors in identification of blood bottles and of patients, haemolytic transfusion reactions due to incompatibility may well be supplanted by cardiac overload as the major risk of transfusion.

With this danger in mind it is obvious that blood should be given to a case of chronic anaemia only as a last resort, and always with full precautions. As the need in chronic anaemia is for red cells and not primarily for plasma, sedimented or "packed" cells should be used. Ideally the cells should be washed free from plasma and given suspended in isotonic saline. The slight advantage gained by such washing is, however, outweighed by the risks of contamination which dog each additional manoeuvre. Should the sedimented cell preparation prove too viscous there can be no objection to a simple addition of sterile, pyrogen-free isotonic saline to the bottle.

In any event, the blood must be given very slowly and, if considerable volume is required, the preference is for smaller amounts given daily or every second day over a period rather than for any attempt to give the whole dose as one prolonged infusion. During transfusion the patient must be watched constantly, with particular attention to any suggestion of dyspnoea, to the appearance of a dry cough or engorgement of neck veins.

To review briefly the circumstances under which blood should be given to or withheld from a patient with chronic anaemia, such cases may be divided into three broad and overlapping groups:

(1) Where specific therapy is available and blood seldom indicated.

(2) Where improvement of the blood picture depends on treatment of a primary disease and where transfusion is occasionally required.

(3) Where blood transfusion is the mainstay of management.

In all that follows it will be presumed that, on clinical suspicion of anaemia, reasonably accurate determinations of red cell count, haemoglobin level and white cell count have been made and that a stained blood smear has been examined. Anything less is inadequate and more is often required for precise diagnosis.

Where Blood Should Seldom be Used

If blood examination shows hypochromic anaemia the common possibilities are of nutritional iron deficiency through poor diet or defective absorption associated, more often than not, with chronic blood loss. Menorrhagia and repeated pregnancies render women particularly liable, while peptic ulcer, oesophageal varices, haemorrhoids and gastrointestinal neoplasms are common to both sexes. Though search for such lesions must be especially thorough in men, neither should it be neglected in women, because administration of iron will, in almost every case, improve the blood picture. Only relapse after a longer or shorter interval would indicate the need for further investigation.

The source of blood loss, if present, having been dealt with, treatment of the anaemia is almost invariably simple and effective. Iron in the form of ferrous sulphate by mouth and in adequate dosage is the routine. Occasionally the patient is intolerant of or unresponsive to such a regime. Occasionally the imminence of a major operation or of labour gives insufficient time to achieve adequate blood levels by this means. It is under these circumstances that blood transfusion is commonly and correctly used.

However, the intravenous use of saccharated oxide of iron has recently been shown sometimes to be of value where oral medication is unsatisfactory (Nissim[2]; Nissim and Robson[3]). Gastrointestinal intolerance and non-absorption are thus thwarted. Further, the rate of haemoglobin increase is considerably more rapid than with oral iron. A single dose of 200 mgm. is equivalent in iron content to a pint of blood, and is free from the dangers which inevitably accompany transfusion.

Within the past few weeks saccharated oxide of iron for intravenous use has been placed on the North American Market under the trade name of Feojectin.

There remain only those cases where urgent operation or labour must occur within a matter of a few days. Blood transfusion is then indicated, but the hazards outlined in the Introduction must be constantly borne in mind.

Somewhat similar considerations influence transfusion in those suffering from Addisonian pernicious and other megaloblastic anaemias. With potent liver extracts and especially with the recent availability of Vitamin B_{12}, transfusion should very seldom be used in true Addisonian pernicious anaemia. The lower the blood levels the greater the risk of precipitating cardiac failure. With the almost complete certainty that the case will respond to Vitamin B_{12} within a few days the risk of leaving a patient in bed with adequate nursing care is probably much less than the risk of giving blood.

The so-called pernicious anaemia of pregnancy deserves special comment. There is macrocytic anaemia and megaloblastic erythropoiesis associated with free hydrochloric acid in the gastric juice of a pregnant woman. Not infrequently the picture is "dimorphic", that is, with co-existing iron deficiency. This form of anaemia improves after delivery, and does not necessarily return during subsequent pregnancies. Folic acid with iron if indicated, will relieve the anaemia and treatment can be discontinued at the end of pregnancy. Again it is only if diagnosis has been reached too late that the proximity of labour would necessitate transfusion.

Megaloblastic anaemia due to dietary deficiency or to defective absorption, as in sprue, usually respond to Vitamin B_{12}, but cases in whom the response is laggard may benefit from careful transfusion.

The special case of Achrestic Anaemia of Wilkinson will be mentioned later.

Where Transfusion Should Occasionally Be Used

There are certain diseases accompanied by anaemia in which relief of the anaemia depends essentially upon relief of the primary disease. In renal failure, for example, anaemia is variable in degree and may be severe. It will not respond to ordinary haematinic therapy and transfusion may benefit the patient temporarily, even in the presence of hypertension and symptoms of uraemia. Where the renal lesion is irreversible it is, of course, futile to give blood after uraemic coma has supervened. Naturally, where hypertension is present transfusion will be attended by the risk of precipitating cardiac overload and suitable precautions must be taken.

Many prolonged infections are also accompanied by anaemia. The introduction of sulphonamides and antibiotics has rendered this problem of less significance, but, nevertheless, cases will be encountered in which the infective process becomes indolent and improvement of the peripheral blood picture by transfusion often improves the general response of the patient.

Anaemia is a frequent concomitant of leukaemia, Hodgkin's Disease and other disorders of this class. In part the anaemia is apparently due to replacement of erythropoietic tissue and sometimes there is a haemolytic element. Transfusion is of considerable value in relieving anaemia in the chronic types of these disorders, although it is scarcely justifiable in the terminal stages. But the main controversy is on the question of transfusion in acute leukaemia. Cases have been reported in which massive or exchange transfusions have resulted in remarkable clinical remissions associated with restoration of the peripheral and marrow pictures to normal. Indeed, two patients are supposed to have recovered. If acute leukaemia is accepted as a neoplastic process of rapid development it is difficult to believe that administration of blood can effect a cure. Merely a temporary benefit lasting only days or a week or so is very hard to justify, because it means that the unfortunate patient has to traverse the downhill path twice. While small transfusions of fresh blood may help considerably by alleviating haemorrhagic manifestations if present, it is felt that much more definite evidence must be presented before massive or exchange transfusions are justifiable in acute leukaemia.

Where Blood Is the Mainstay

There are various blood dyscrasias for which, with the exception in some instances of splenectomy, there is no treatment other than transfusion. The most obvious example is the group of aplastic anaemias, both primary and secondary. In some cases aplasia follows a definite cause such as exposure to an organic arsenical and the marrow shows arrested development of the normoblast series. In these recovery is likely and transfusion is invaluable in carrying the patient through the phase of anaemia. In other cases there is no such cause and biopsy shows the marrow to be truly aplastic. Such cases are inevitably fatal and some recommend that transfusion be withheld on the ground that it is, in the long run, useless. However, enough records have been published of such patients being carried through months or even years of additional life by multiple transfusions to make it impossible for a clinician to withhold blood.

Israels and Wilkinson[1] have given the name of achrestic anaemia to instances of megaloblastic

anaemia with free HC in the gastric juice, which are free from gross liver disease and yet fail to respond to any form of haemopoietic substance. Such cases must be rare but, when encountered, transfusion is obviously essential despite the hopeless outlook.

Where anaemia is due to replacement of marrow, as by carcinomatosis, transfusion is the only available remedy. In cases with a rapidly downhill course transfusion is pointless, but in those with a more protracted course, such as in myelosclerosis, transfusion is essential. Incidentally, where pain is due to increase in the size of the spleen in this group of diseases, transfusion, by cutting down demands on extramedullary haemopoietic foci, may relieve the pain by temporarily inhibiting increase in the size of the organ.

Transfusion is of great significance when the haemolytic anaemias are considered. In phases of acute intravascular haemolysis such as occurs with incompatible transfusions, Lederer's anaemia and, in the tropics, blackwater fever, transfusion not only restores red cells but, more important, it combats the grave shock which accompanies such episodes and which in all probability is responsible for consequent renal failure, the cause of death in many of these patients.

In sickle-cell anaemia and Cooley's anaemia, transfusion is of very limited value. In nocturnal haemoglobinuria cells washed free from plasma must be used (Dacie)[5]. Where anaemia is due to a chemical agent, such as lead, the first stage in treatment is to remove the patient from exposure and transfusion is of value limited to the active phase. With sulphonamides haemolysis in sensitive patients is often rapid and profound; transfusion will mitigate haemolytic shock and replace red cells once the offending substance is withdrawn.

Of greater importance are the haemolytic anaemias of the congenital and acquired varieties. In the congenital variety transfused red cells survive for a normal length of time and splenectomy is almost invariably of benefit. On the other hand, in the acquired variety in patients in middle life or later, there is apparently a circulating autohaemolysin. Splenectomy is of doubtful value and transfused red cells have a considerably shortened life span. In both these types of haemolytic anaemia so-called "crises" occur in which the red cell levels fall precipitously. These episodes have been shown to be due, not to an exacerbation of haemolysis as was previously taught, but to a temporary arrest of erythropoiesis. Transfusion is obviously essential to cover such critical periods.

Associated with the presence of incompatible agglutinins is erythroblastosis foetalis in its various guises. While opinion has yet to be crystallized it would appear that exsanguination transfusion is life-saving in many instances. With a different basis is haemorrhagic disease of the new born, and transfusion of reasonably fresh blood is indicated because of the need for red cells and of the value of prothrombin in the donor's serum.

Finally, there are various other haemorrhagic disorders which require mentioning. As with the new born, deficiency of prothrombin in obstructive jaundice and in gross liver disease may lead to haemorrhage and transfusion will supply both red cells and prothrombin. In purpura associated with thrombocytopenia transfusion will often diminish the haemorrhagic tendency. In the idiopathic variety the patient may thus be tided over critical periods or be made ready for splenectomy. In the symptomatic varieties, which depend upon sensitivity to drugs or upon replacement of marrow by leukaemia or carcinoma, transfusion may check haemorrhage unless the condition is terminal. Finally, transfusion of whole blood was until recently the only method of control in haemophilia. An antihaemophilic fraction of the plasma proteins has now been prepared which will bring coagulation time to normal. This substance is not yet generally available, and in the meantime, small quantities of fresh plasma will maintain the clotting time within normal limits. Whole blood is still essential to replace blood lost.

Summary

No attempt has been made to cover the whole field of blood dyscrasias, but, in a somewhat discursive fashion, the more commonly encountered anaemias have been mentioned, together with their relationship to blood transfusion.

With accurate diagnosis of an anaemia and with the danger of circulatory overloading in mind, it should be possible to determine in any given case whether the patient will bless or curse the use of transfusion.

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PATHOLOGY

Clinical Pathology (8)
The Blood Smear

Paul T. Green M.D.

When it comes to the examination of blood smears, art enters into the scientific picture. A nicely made, well stained smear is a thing of beauty, and it is not an easy thing to produce. There are several reasons for the difficulty in making proper smears:

1. Glass slides are not properly prepared. The slides used for making blood smears must be flat; they must not be ridged or scratched, and above all, they must be clean. New slides, as they come from the manufacturer, are not clean, and should be processed before they are used. A minimum of processing consists in leaving them in glacial acetic acid for a few minutes, washing them well in running water, and then distilled water; passing them through a flame several times to remove grease, and polishing them with a clean, grease-free cloth; preferably old linen that has been well washed out in ether.

As a routine for new or used slides the following is recommended: the slides are placed first in 2% trisodium phosphate solution, and can be left there until enough slides have collected to be processed. They are rinsed in running tap water; and then are placed in sulfuric acid-bichromate solution for an hour or so. This solution is made by adding to commercial sulfuric acid, enough commercial potassium bichromate to produce a dark brown color after a few minutes shaking. Of course, the fingers should not be put into such a cleaning solution unless protected by rubber gloves.

The slides are then removed and washed in running warm water for at least an hour. They are then placed in distilled water to soak overnight. They are then stored in 2:1 ether-alcohol. Before being used they can be removed from the alcohol, using forceps, not fingers, wiped with fat-free cloth, and flamed. If it is so desired, slides can be wrapped ready for use, by placing two slides or so in a fat-free filter paper, wrapping them up and folding over the ends.

2. Making the smear: Most novices tend to make smears too thick. If the smear is too thick the cells are all crowded one on the other and cytological detail cannot be seen. If the smears are too thin, it takes prolonged searching to find enough cells for a differential count. The optimum is to have a smear in which the cells are evenly spread out, so that each cell is barely touching the other cells around it.

In order to make such a smear, a small drop of blood is placed at one end of the glass slide; (the finger of the patient should not touch the slide, only the blood droplet); the edge of another clean glass slide, which should not have any nicks in it, is used as a spreader. With the glass slide which has the drop of blood on it resting firmly on a table, the edge of the spreader is touched to the blood drop, which should at once spread out along the spreader. The spreader is then drawn or pushed, as you prefer, along the slide. Actually, the whole process should occur almost as one motion; one should not wait any length of time for the blood to spread along the spreader, otherwise certain cells, particularly polymorphs., are drawn out to the edges of the smear, and this will spoil differential counts.

Once spread, the smear should be rapidly dried, either by waving it in the air, or holding it in the air stream from an electric fan, or a jet of air. If the smear dries too slowly, the white cells tend to shrivel up, and the red cells tend to become crenated.

It is not difficult to learn to make nice smears from normal blood quickly. A good smear has rather a tongue-shaped contour, and is smooth and even. However, it is not so easy to make such nice smears with abnormal blood. If there is marked anemia, with a relative increase in plasma, smears tend to be too thin and dry too slowly. The thickness of these smears can be varied by the amount of pressure one applies to the spreader. With a moderate amount of pressure, thin smears tend to occur, whereas if little pressure is applied, thick smears result.

Also, where there is a rapid sedimentation rate, or where fibrinogen or globulins are increased the smear tends to be ridged, and the end instead of having a smooth, round contour, tends to be composed of filamentous strands of blood. Myeloma blood produces a greasy sort of a smear, and it is almost impossible in many cases to produce a nice smear. Indeed, with some experience, a fair amount of information about the blood can be guessed from the mere process of making the smear.

3. Staining. In usual types of staining, two processes occur; the smear is first fixed, that is, the cells are so altered that they adhere to the glass slide and do not tend to wash off. This is generally produced by the alcohol which is the vehicle in which stain is dissolved. It should be remembered that when alcoholic stain is first placed on the slide and allowed to remain a minute or so, that this is fixing the slide, and is not doing any staining. Next, it is stained, water is added,

to dilute out the alcohol which has fixed the smear, and staining begins. Difficulties in producing a well stained smear can usually be attributed to one of several things:

1. Poor stain.
2. Improper hydrogen ion concent ation (pH).
3. Stain left on too long before diluted; or left on too long a time or too short a time after dilution.
4. Use of tap water which has a high chlorine content that tends to bleach the stain.

Stain

There are many stains in common use, and each has its advocates. Actually, there is not a great deal of difference between most of them. Giemsa's stain is the prettiest stain and gives best differentiation, but it reques separate fixing of the smear, and it takes a long time to stain the smear, and so it is not used routinely in a busy laboratory. It has one great advantage in that over staining does not occur.

We have found that Leishman's stain is very satisfactory. It is best to make up the stain oneself. The powdered stain marketed by B.D.H. is satisfactory. The alcohol used to dissolve the stain must be absolute methyl alcohol and must be acetone free. This alcohol takes up water from the air, and therefore must never be left unstoppered, either before it is used, or after the stain has been dissolved in it.

As the stain tends to improve with age, it can be made up in fair quantity. It is best ground to a fine powder in a mortar, and then about 200 mg. is added to 100 cc. of the alcohol and it is shaken and put away in a dark cupboard for a day or so. There should be some undissolved powder left at the bottom of the bottle. If not, add a bit more of the powdered stain.

To use the stain, place enough stain on the slide to cover the film. Leave it on for about a minute, and then add about twice the amount of buffer; and leave for about three minutes before washing off. Different batches of stain may have different times for optimum staining, but with a good stain it is not necessary to be precise about timing. When stained, the smear should be washed off in a running stream of distilled water or buffer. Do not dunk it into a stationary water supply, as otherwise a film of precipitated stain from the surface of the water is caught on the smear as it is withdrawn from the water, and this gives the whole smear a dirty appearance when it is being examined.

Incidentally, when a smear has been stained, and it is discovered that the staining was not good, you need not discard the smear. It can be restained; but leave the undiluted stain on a while longer than usual, so that it can dissolve out the previous stain.

Hydrogen Ion Concentration

If the pH of the stain solution is too acid, the smear tends to stain very red, and the nuclei of the white cells do not stain well. If it is too alkaline, on the other hand, it tends to stain too blue. In order to obtain the proper pH concentration, then, it is much better to use a buffer solution to dilute the stain instead of water. For Leishman's stain the optimum pH is 6.8, and the following buffer can be used:

Stock: 25 gm. Disodium Phosphate.
32.5 gm. Sodium dihydrogen phosphate.
100 cc Water.

For Use

Take 2 cc. of the stock and dilute up to 100 cc. with distilled water.

Once stained and washed the smear is allowed to dry before being examined under oil emersion. It can be examined under lower powers while wet, to see if the staining seems to be alright, and the smear is well spread.

Emersion Oil

The old cedar oil is passing out of vogue, as it is sticky, and tends to form a resinous film after exposure to the air. Special emersion oils (for example the Crown emersion oils) are superior. Emersion oil can be easily made by taking mineral oil, in a bottle, placing a glass stirring rod into it; and then slowly add brom-benzene, while stirring, until the glass rod "disappears". The refractive index of the mixture is now the same as glass, and so the rod cannot be seen when in the solution. However, it is more convenient to buy the emersion oil.

Examination of the Smear

Examination of the smear, now that it is properly made and stained, is an art that must be learned by experience. It is almost useless to describe various types of cells. If I were to ask you to meet my cousin, whom you had never seen, at the corner of Portage and Main, and described his appearance as best I could, you would probably have considerable difficulty identifying him from the description, whereas I would recognize him at once because I know what he looks like. This is how we recognize cells; by knowing what they look like. The appearance of red cells, platelets, and the various white cells in health and in various diseases is something one has to see repeatedly in order to appreciate. It is rather a pity that the physician who would never dream of not listening to a patient's heart, is quite content to take the word of the technician as to what the patient's cells look like.

In doing differential white cell counts, the accuracy depends to a great extent on the ability of the counter to differentiate the various types of

cells. The qualitative changes that occur in these cells are not generally expressed in a differential count, but should be noted on the report.

The accuracy of differential white cell counts depends also on the caliber of the smear; how the differential count is made, and how many cells are counted.

If the smear has been made slowly, polymorphs and eosinophiles tend to collect around the edges of the smear, and if the technician is in a hurry and not too conscientious, she may count the cells at the edges, because there are more of them there. The result may be a false increase in polymorphs. If, on the other hand, the differential count is made mainly in the middle of the smear a falsely high lymphocyte count may result.

At least 200 cells must be counted in order to approach a sample that tends to give a consistent differential; and the count should be made across the entire thickness of the smear, and at several places, and preferably, on two separate smears.

Counting Chamber Method

In order to overcome the technical errors that can be introduced into a differential count by making a smear, a counting chamber method has been devised that has a greater reproducibility, once one learns to recognize the appearance of the cells in this method. This should not replace the making of a smear, but should augment it. The total white count and differential may be made by this method, but a smear should be made in order to study the more subtle morphological features.

Stock Solutions:

1. 0.1% Methylene blue dissolved in propylene glycol.
2. 0.1% phloxine dissolved in propylene gycol.

These solutions keep well.

Working Stocks:

Made by mixing equal amounts of the stocks with water, and these solutions keep a few weeks.

For Use:

Mix equal amounts of the working stocks. These keep only four hours. The solution is now used just as if it were white cell diluting fluid, and the pipette is filled, shaken, and the counting chamber filled as in doing a white cell count. The white cell count is then made under low power, and then the high power is used, and a differential count is made on 200 cells.

Expression of Differential Counts

The numbers of each cell type present may be expressed as either a % of the total white cell count, or better, in absolute terms; that is the number of each cell type present per cubic millimeter of blood.

NORMAL VALUES, from Wintrobe, are:

	%	Absolute range
Juvenile neutrophiles	3-5%	150-400
Segmented Neutrophiles	54-62%	3,000-5,800
Eosinophiles	1-3%	50-250
Basophiles	0-.75%	15-50
Lymphocytes	25-33%	1,500-3,000
Monocytes	3-7%	285-500

CANCER

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Abstract

Coley, Bradley L., et al. An analysis of fifty-nine cases of Osteogenic Sarcoma with survival for five years or more. The Jour. of Bone & Joint Surgery. 32-A: 307-310, 1950.

In the period of 1917 to 1940, 245 cases of osteogenic sarcoma were treated at Memorial Hospital, New York. In this group 21.9% were regarded as having been treated successfully. This paper deals with the analysis of these cases which survived. The term ostogenic sarcoma is used to include chondrosarcoma, medullary and periosteal spindle cell sarcomas. The latter two groups formed 67.6% of the series. The authors make the following observations:

1. It is worthwhile separating the various types of sarcomas in the osteogenic group since the fibrosarcomas and chondrosarcomas have a more favourable prognosis. The micoscopic examination affords a reliable index of activity.

2. Only three of the cases were treated by non-surgical procedures (radiation and/or toxins). Of the fifty-seven treated by surgery, fifty-one had radical procedures, the remaining six (chondrosarcomas) were treated by conservative surgery.

3. The part played by radiation is difficult to determine. In the past five years pre-operative radiation has been abandoned.

4. Toxin treatment is no longer used.

5. There were no five year survivals where the lesion was located in the proximal end of the femur.

6. Five year survival is an insufficient period of time on which to base cure since 8.5% of the above series died after surviving for five years.

7. Two cases had lobectomy for pulmonary metastasis. One is alive and well three years after lobectomy, and eight years after amputation. This was in a case of low-grade chondrosarcoma.

D. W. P.

CASE HISTORIES—SURGICAL

Acute Obstructive Cholecystitis Cholecystectomy

S. S. Peikoff, M.D., F.R.C.S. (Ed.), F.R.C.S. (C), F.A.C.S.

This is the eighth of a series of Case Histories which will appear in the Review each month. The purpose of these publications is not to present rare or unusual cases but rather to consider the routine management of common surgical conditions.

Case No. 47-12,976, Mrs. W. F., St. Boniface Hospital. Color, white. Age, 68. Occupation, scrubwoman. Date of Admission, October 9, 1947. Date of operation, October 9, 1947. Date of discharge, October 19, 1947.

Complaint on Admission

1. Pain in epigastrium, 28 hours. 2. Vomiting, 3 hours.

Present Illness

For many years (15-20?) patient has had mild, bouts of indigestion, and belching of gas. Occasionally fat foods, such as ham or fried foods would give her an uncomfortable pressure in the pit of the stomach—but she never had any pain to speak of. About 2 weeks ago (September 15, 1947) she was suddenly seized with severe epigastric pain, which continued for several hours. This pain radiated to her back and made her "break out in a cold sweat". She took some baking soda and a hot water bottle, and the pain gradually wore off. She did not vomit at this time, but was nauseated. On October 1, 1947, approximately one week later, she was again seized with the same kind of an attack. This lasted much longer. Her doctor was called, and gave her a "hypo". She vomited most of the night. Took a dose of Eno's Fruit Salts in the morning and felt immediate relief, although she was left with soreness for several hours. On October 8, 1947, at 11 a.m., while preparing lunch, she was again seized with severe abdominal pain. This continued for several hours. Neither a hot water bottle, fruit salts or baking soda had any effect. About 3 p.m. she began to vomit. The pain became very severe and was continuous without a "let-up". Pain was stabbing in nature through to her back and right shoulder, going through her like a knife-blade. She called her doctor, who gave her a "hypo". This gave her very little relief. She vomited everything. About 2 a.m. she called her physician again. He tried to have her hospitalized, but she felt it would subside, as it did on two previous occasions. She spent a very miserable night. On October 9, 1947, she was admitted to the hospital about 2.30 p.m.

Inventory by Systems

Eyes—Vision fair. Reads with glasses. No diplopia.

Ears—Hearing good. No tinnitus.

Throat—Does not get sore throat. Mouth and lips very dry.

Repiratory—Does not get colds. No cough. No dyspnoea. No haemoptysis. At present deep inspiration or cough gives her pain in right upper part of abdomen.

Cardio-vascular—No palpitation. Some retrosternal pain.

Genito-urinary—Occasional nocturia (1-2 times). No pain on micturition. Frequent incontinence on straining. No haematuria.

Gastro-intestinal—See present illness.

Menstrual—Menarche age 13 years. Menses always regular. Interval 26 days. Duration 4-5 days. No discharge. No intermenstrual bleeding. No dysmenorrhoea. Some pruritis recently. Menopause at 43 years. No discharge or bleeding since.

Obstetrical—Para xii; gravida xii. All babies delivered by midwife. Easy deliveries. No complications. No miscarriages.

Past History

Does not recollect any illnesses, operations or accidents. Has always been a hard-working woman—at present takes in laundry in addition to her own farm work.

Family History

Mother—Died at age 82—apoplexy.

Father—Died at 78—"bladder trouble".

Husband—Age 70—alive and well.

Ten children—alive and well.

Two children died in infancy—cause unknown.

No history of tuberculosis or malignancy, etc., in family.

Physical Examination

Fairly stout, gray-haired lady, lying still in bed in a semi-supine position, moaning with pain.

Head and Neck:

Cranial Nerves—Intact. No palsy.

Eyes—No proptosis of eyes or drooping of lids. Pupils equal in size, react to light and accommodation. Fundi: no haemorrhage, retinitis or evidence of sclerosis.

Ears—Canals and drums normal.

Nose—Normal. No obstruction.

Tongue—Furred heavily.

Lips—Very dry. Good color.

Face—Flushed. Perspiring freely over forehead.

Teeth—Fair.

Neck—Thyroid not palpable. No Adenopathy. Veins not extended.

Chest:

Heart—Normal size. Apex beat 3½ inches from midline in 5th interspace. Heart sounds regular. Good rhythm, strong. Beats 110 per minute. No murmurs.

Lungs—Thoracic cage normal. Movements increased and slightly heaving on inspiration. No dilated veins. No dullness on percussion. Few fine creps at base of right lung.

Mammae—Moderate size. Equal and symmetrical. No masses felt. Nipples and areolae normal.

Abdomen—Moderately distended. Movements restricted. No apparent localized swelling. Palpation: marked rigidity over entire right upper quadrant of abdomen, including medial portion of left upper quadrant and extending as far as the umbilicus. By gentle pressure on left side above and in right lower quadrant, rigidity can be overcome. Marked tenderness in right upper quadrant. Rebound tenderness severe. A large rounded swelling can easily be demarcated to the right of the anterior axillary line and at a point midway between the costal margin and the anterior superior spine. This mass moves freely with respiration: is oval and resembles a large gall bladder outline. Abdominal reflexes—right ††—left ††.

Vaginal examination — Marked varicosities on labia. Introitus lax. Cystocele and rectocele grade iii, with moderate uterine prolapse. Cervix lacerated and eroded. Uterus small and freely movable. No masses felt in pelvis.

Rectal examination—Not done. On inspection, moderate mixed haemorrhoids. Normal curvatures. Free movements. Very tender on light fist. Percussion of right lumbar region.

Extremities—Upper—No wasting. Hands feel warm and good color. No deformities. No clubbing of fingers.

Reflexes:	Right	Left
Biceps	††	††
Triceps	††	††
Supinators	††	††

Lower—No deformities. No wasting. Incompetent saphenous vein left side with marked varicosities. No oedema or ulceration. Normal pulsations of dorsalis pedis and posterior tibial. Vibration sense normal.

Reflexes:	Right	Left
Knee	††	††
Ankle	††	††
Plantar	V	V

Urinalysis—October 9, 1947—Color, amber. Reaction, acid. Specific gravity, 1.026. Chemical: Sugar 0; Albumin 0. Microscopic, 5-6 pus cells per h.p.f. Occasional finely granular casts. Bile, none present.

Blood—Red blood cells 4,462,000. Hemoglobin, 92%. White blood cells, 22,000. Polymorphonuclear Neutrophiles 92%. Lymphocytes 8%.

Icterus Index—12. Blood Amylase: not increased.

Pre-operative Diagnosis

Acute obstructive cholecystitis.

Indications for Operation

The acute onset of severe epigastric pain, later localizing in right upper quadrant and rediating to the scapula; the definite rigidity and tenderness in the right upper quadrant with a palpable mass suggesting a gall bladder; the constant pain not relieved by morphine; leucocytosis and pyrexia, all suggest an obstructive lesion in the gall bladder or cystic duct with inflammatory reaction.

The question as to whether the patient should be operated on immediately or within several days, or wait for the attack to subside completely under conservative regime, has been subject to considerable debate.

I personally favor an early operation—that is, sufficient time to be allotted to confirm the diagnosis; assess the patient as to surgical risk (hypertension, diabetes, cardio-renal), and overcome the dehydration and fatigue which most of these patients suffer. I have now done over 30 of such cases and am convinced that if operation is done within 24-72 hours, the mortality is practically nil; the operation comparatively easy; complications such as perforation, localizing abscess, etc., may be obviated; and severe irreparable damage to the biliary duct system and liver may be averted.

Pre-operative Care

In spite of her age the patient was in good physical condition and without evidence of cardiac, renal or respiratory involvement. The fatigue and dehydration was overcome by sedative and glucose 5% with saline 2000 ccs., and gastric suction was established to relieve distension.

Patient was operated on within six hours of admission and within 28 hours of onset of symptoms.

Detailed Description of Operative Technique and of Operative Findings

Position—Supine. Gastric suction maintained. Skin painted with merthiolate.. Draped.

Incision—Right Kocher oblique subcostal incision was made, extending from the xiphoid process downwards and outwards, for about 6 inches.

Skin—Superficial fascia and aponeurosis of external oblique covering the rectus abdominus and internal oblique were incised in the same line. The rectus muscle was defined partially transected in the medial part of the wound, while fibres of the external and internal oblique were divided in the

outer part of the wound. The superior epigastric artery within the rectus sheath was cut and ligated with chromic catgut 00. The 8th intercostal nerve in the outer part of the wound was retracted upwards. Skin towels were applied.

The transversalis fibres and its fascia were divided in the same line and the peritoneum was incised the full length of the incision.

Immediately on opening the abdomen, an enormously distended and enlarged gall bladder popped out through the wound. The plum-colored grayish fundus projected fully 1½ inches in front of the anterior surface of the liver. At the apex of the fundus, the wall had undergone a blackish gray discoloration. The greater omentum was adherent to and partially enveloped the fundus and Hartman's pouch. This was easily wiped off the gall bladder with finger gauze dissection.

An automatic abdominal retractor was inserted and the gall bladder completely packed off from all surrounding area.

The tensely distended gall bladder was then aspirated with a large bore needle and 50 cc. syringe. The initial contents were whitish mucoid material, which soon became dark and haemorrhagic. When the gall bladder was deflated one could feel the thick oedematous, rather rigid walls. Numerous small stones could be felt in the fundus and one large stone about ¾ of an inch in diameter was firmly impacted in Hartman's pouch.

Since the walls of the gall bladder appeared thick and friable, a curved intestinal forceps with flat blades (instead of the usual curved haemostats) was placed on the fundus and used for gentle traction. The peritoneum on each side and over the gall bladder was incised for about ⅛ of an inch thickness. The oedematous bed of the gall bladder permitted easy separation of the gall bladder from its bed by ordinary finger dissection from above downwards. The stone in Hartman's pouch was seized with the fingers of the left hand, and used as a means of drawing the gall bladder from its liver bed and putting the mesentery under tension.

The cystic artery was easily found in the oedematous tissue, clamped, cut and ligated with chromic catgut i, close to the gall bladder. The stone in Hartman's pouch was milked up into the body of the gall bladder. The cystic duct was palpated, but no stones were found. The cystic gland was enlarged and could be palpated and visualized. The cystic duct was clamped, cut and ligated, and the gall bladder removed. The edges of the peritoneal leaves forming the boundaries of the gall bladder bed were oversewn with continuous lock sutures of No. 1 chromic catgut. All debris was aspirated with mechanical suction. The common bile duct was palpated, but not visualized, since there was no indication for its exploration.

A large Penrose drain was inserted at the foramen of Winslow, directed along Morrison's pouch and brought out through a stab drain.

Closure—The Kocher incision was closed in layers. The transversalis fascia and peritoneum were closed with continuous chromic catgut No. 1.

The external oblique was sutured with interrupted silkworm gut sutures.

Anaesthetic

Pre-medication—Morphine gr. ¼ with atropine 1/150 pre-operatively.

Condition of patient—Temperature 100.2° F. Respirations 22. Pulse 120. Blood pressure 142/80.

Agents—Pentothal 2½ ccs. intravenously. Nitrous oxide and oxygen. Curare 6 ccs.

Technique—Closed—orotracheal.

Comments — Intravenous glucose continued. Penrose drain. Maintenance satisfactory. No haemorrhage.

Gross and Microscopic Description of Tissues Removed

Tissue No.: 3544-5.

Gross — Enlarged and very congested. Wall oedematous and yellowish green. Thickness varies from 1 to 2 centimeters. (Rupture at fundus). Lining is of dull grayish-red color coated with fibrin here and there. About two dozen small black calculi of small B.B. shot size, and one olive-sized stone.

Microscopic—Acute cholecystitis. All coats involved. Mucosa necrosed in areas.

Final Diagnosis

Acute obstructive cholecystitis.

Progress Notes Including post-operative Care During Stay in Hospital

October 9, 1947—Returned to ward in good condition. Pulse 120. Respirations 28. Blood pressure 105/65. Gastric suction continued. Blood 500 cc. with glucose 5% in saline 1000 cc. given. Sedative, morphine gr. 1/6. Turned frequently from side to side. Carbon dioxide hyperventilation 5 minutes every hour. Penicillin, 50,000 units OH iv .

October 10, 1947—Restless. Face flushed. Temperature 101° F. Blood pressure 115/65. Enema given with good result.

October 14, 1947—Penrose drain removed (previously shortened ½ inch daily). Up out of bed.

October 17, 1947—Stitches removed. Up and around. No complaints. Wound well healed.

October 19, 1947—Discharged.

Condition on Discharge

Excellent.

Follow-Up Notes Since Leaving Hospital

March 10, 1948 — Patient was referred by a physician practicing in the country. Last report patient in excellent condition. No further attacks of dypepsia or colic. Still works hard at her home and as scrubwoman, without being off work at any time.

Medico-Historical

J. C. Hossack, M.D., C.M. (Man.)

Spanish Practice

The Spanish medical man is shunned, not only from ancient prejudices, and because he is dangerous like a rattlesnake, but from jealousies. Thus the universities, governed by ecclesiastics, persuaded the poor bigot Philip III to pass a law prohibiting the study of any new system of medicine, and requiring Galen, Hippocrates, and Avicenna. Dons and men for whom the sun still continued to stand still, scouted the exact sciences and experimental philosophy as dangerous innovations, which, they said, made every medical man a Tiberius, who, because he was fond of mathematics where strict demonstration is necessary, was rather negligent in his religious respect for the gods and goddesses of the Pantheon; and so, in 1830, they scared the timid Ferdinand VII (whose resemblance to Tiberius had nothing to do with Euclid) by telling him that the schools of medicine created materialists, citizen-kings, chartists, barricadoers, and revolutionists. Thereupon the beloved monarch shut up the lecture-rooms forthwith.

This low social position is very classical: the physicians of Rome, chiefly "liberti", freed slaves, were only made citizens by Caesar, who wished to conciliate these ministers of the fatal sisters when the capital was wanting in population after extreme emigrations—an act of favour which may cut two ways; thus Adrian VI (tutor to the Spanish Charles V) approved of there being 500 medical practitioners in the Eternal City, because otherwise "the multitude of living beings would eat each other up." However, when his turn came to be diminished, the grateful people serenaded his surgeon, as the "deliverer of the country." In our days, there was only one medical man admitted by the Seville **sangre su**, the best or noblest set (whose blood is held to be blue, of which more anon) when in rude and antiphlebotomical health; and every stranger was informed apologetically by the exclusive Amphitryons that the M.D. was **de casa conocida**, or born of a good family; thus his social introduction was owing to personal, not professional qualifications. And while adventurers of every kind are betitled, the most prodigal dispenser of Spanish honours never dreams of making his doctor even a **titulado** a rank somewhat higher than a **pair de France**, and lower than a medical baronetage in England. This aristocratical ban has confined doctors much to each other's society, which, as they never take each other's physic, is neither unpleasant nor dangerous. At Seville the medical **tertulia**, club or meeting, was appropriately held at the apothecary's shop of Campelos, and a sable junta or consultation it was, of birds or bad omen, who croaked over the general health with which the city was afflicted, praying, like Sangrado in 'Gil Blas', that by the blessing of Providence much sickness might speedily ensue. The crowded or deserted state of this rookery was the surest evidence of the hygeian condition of the fair capital of Baetica, and one which, when we lived there, we have often anxiously inspected; for, whatever be the pleasantries of those in insolent health, when sickness brings in the doctor, all joking is at an end; then he is made much of even in Spain, from a choice of evils, and for fear of the undertaker.

The poor in no countries have much predilection for the hospital; and in Spain, in addition to pride, which everywhere keeps many silly sick out of admirably-conducted asylums, here a well-grounded fear deters the patient, who prefers to die a natural death. Again, from their being poor, the necessity of their living at all, is less evident to the managers than to the sufferers; as, say the Malthusians, there is no place vacant at Nature's table d'hote to those who cannot pay, so bed and board are not pressed on Spanish applicants by the hospital committee; an admitted patient's death saves trouble and expense, neither of which are popular in a land where cash is scarce, and a love for hard work prevalent, where a sound man is worth little, and a sick one still less; nor is every doctor always popular for working cures, as could be exemplified in sundry cases of Spanish wives and heirs in general; therefore in the hospitals of the Peninsula, if only half die, it is thought great luck: the dead, moreover, tell no tales, and the living sing praises for their miraculous escape. **El medico lleva la plata, pero Dios es que sana!**—God works the cure, the doctor sacks the fee! Meanwhile the sextons are busy and merry, as those in Hamlet, and as indeed all gravediggers are, when they have a job on hand that will be paid for; deeply do they dig into the silent earth that bourn from whence no travellers return to blab. They sing and jest, while dust is heaped on dust, and the **corpus delicti** covered, and with it the blunders of the medico; thus all parties, the deceased excepted, are well satisfied; the man with the lancet is content that disagreeable evidence should be put out of sight, the fellow-labourer with the spade is thankful that constant means of living should be afforded to him; and when the funeral is over, both carry out the proverbial practice of Peninsular survivors: **Los muertos en la huesa, y los vivos a la mesa**, the dead in their grave, the quick to their dinner.

Richard Ford.
"Gatherings from Spain (1846)

ARTICLE

Impressions from the First International and Fourth American Congress on Obstetrics and Gynecology

Ross Mitchell, M.D.

This Congress, held in the Hotel Statler, New York City, May 14-19, 1950, was sponsored by the American Committee on Maternal Care which grew out of the White House Conference on maternal and child welfare. The Chairman of the Committee is that grand old man of American Obstetrics, Dr. Fred L. Adair, and it was he who gave the address of welcome at the opening meeting of this Congress on May 15.

The Chairman of the General Programme Committee was Howard C. Taylor, Jr., of New York, and of the subcommittee on the Medical Section of the programme was Newell W. Philpott of Montreal.

Countries other than the United States and Canada represented on the programme were Italy, Sweden, France, Israeli, Spain, Switzerland, Scotland, India, Japan, Argentina, Germany, England, Norway, Mexico, Australia, Brazil, Yugoslavia, Ireland, Chile, Holland, China, West Africa, Austria, Denmark, the Philippines, Finland, Cuba, Czechoslovakia and Uruguay. But for the absence of Russia it might have been a meeting of United Nations. To heighten the similarity, International Business Machines Corporation had provided headphones which could be adjusted so that the hearers might listen to French, German, Spanish and English. Interpreters were stationed in booths in the gallery. The vast majority of the foreign speakers gave their addresses, sometimes haltingly, but usually in quite fluent English. A professor from Buenos Aires spoke in Spanish which an interpreter broadcast in English practically simultaneously. The arrangements for the meeting were good, save that the Keystone Room where the general interest programmes were delivered could not accommodate all who wished to hear.

There was an embarrassment of richness of programme, so that at times it was difficult to make a choice. On the first session it lay between the Normal Physiology of Reproduction on the one hand and Difficult Delivery on the other. The former had as speakers Arthur Hertig of Boston, Professor Courrier of Paris, Bernhard Zondek of Paris, S. R. M. Reynolds of Baltimore and Professor Botella Llusia of Madrid; the latter had George B. Maugham of Montreal, speaking on the Clinical Approach to Dystocia; R. F. Nicodemus of Danville, Pa., on Breech Delivery; Gerald W. Gustafson of Indianapolis, on Occiput Posterior Position and Louis M. Hellman of Baltimore, on Uterine Inertia. This writer chose the latter. The Canadians on the programme of the meeting acquitted themselves well and were accorded a good reception.

The second general session was on Neoplastic Disease. The speakers and discussants were Hans L. Kottmeier of the famed Radiumhemment of Stockholm, Sweden; John L. McKelvey of the University of Minnesota; Heinrich Martius of Gottingen, Germany; Charles D. Read of London; H. F. Traut of San Francisco and R. Bredland, Norwegian Radium Hospital, Oslo.

The symposium on Caesarean Section as usual provoked a lively discussion. The moderator was R. G. Douglas, Cornell U. Medical School, New York, and the speakers were H. L. Schmitz, Loyola U., Chicago; C. McIntosh Marshall, Liverpool; S. A. Cosgrove, Columbia U., New York, and V. M. Aviles, U. of Chile, Santiago. Discussion in the question and answer period ranged largely on the type of operation, classical low transperitoneal or extra-peritoneal. One of Marshall's dicta was: "There is one indication for the classical operation, and that is a postmortem section."

An innocent looking announcement on the programme might conceal an interesting clash of opinions. On the topic "The Evolution of British Maternity Services," the two speakers were Dorothy W. Taylor, Senior Medical Officer for Maternity and Child Welfare, Ministry of Health, England, and Joseph S. Collings, Research Fellow, Harvard University, Boston. Dr. Collins is an Australian who was assigned by the Nuffield Trustees to make a survey of general practitioner practice in England and whose report, not always laudatory, published in the Lancet of March 25, aroused much comment.

The symposium on Diabetes in Pregnancy, assigned to Priscilla White, Boston; W. P. Givens, New York; Charles H. Read, Boston, and R. Levine, Chicago, was very interesting and helpful.

The banquet in the ballroom on the night of May 17 was a pleasant affair. At the table with the writer were Dr. and Mrs. Birch of Kalamazoo, Mich.; Dr. and Mrs. Burns of Rockford, Ill.; Dr. and Mrs. Popp, California, and Dr. Ernest Couture, head of the Department of Maternal and Child Welfare, Ottawa. Dr. Birch served in the Second World War and after the American occupation of southern Germany he was Medical Officer of Buchenwald. The after-dinner speakers were Fred L. Adair, Benjamin P. Watson, Mrs. Rustin McIntosh, Dean of Barnard College, University of Columbia, who in addition to a remarkable scholas-

tic record is the wife of the Professor of Obstetrics in Columbia University and mother of five children, and Harold Stassen, President of the University of Pennsylvania. The latter's topic was "Freedom in Medicine" and he declared his opposition to state-aided medicine which President Truman is believed to favor.

Other discussions and symposia heard and enjoyed were on the Rhesus Factor, Pathology of Reproduction and Sterility.

The scientific and educational exhibit and the technical exhibits contained much to interest and inform.

Lest it be thought that it was all work and no play, we took occasional time off. The morning of May 19 was spent in a three-hour sightseeing cruise around the island of Manhattan. We saw the Ile de France being docked, also an American aircraft carrier and other war vessels gathered in the Hudson and Brooklyn harbor for a review of armed forces on the following day. Other sightseeing tours were bus trips through Upper New York which included a visit to the unfinished Cathedral of St. John the Divine, and another through lower New York where one saw the entrance to the new Battery-Brooklyn tunnel which was opened to traffic on May 27, Chinatown, and the Queen Mary sailing out of the Harbor. Visits were made to Rockefeller Centre, the Public Library, the museum of the City of New York, the magnificent Frick collection of Art, the Hayden Planetarium and The Cloisters.

Broadway at night had to be explored, and my wife, daughter and I saw "Mr. Roberts," "Kiss Me Kate," and "Gentlemen Prefer Blondes" with Carol Channing. We also saw two good movies, the Rockettes and the staging of a television show and a radio play and Album of Familiar Music.

All in all it left us rather breathless and wide-eyed. We left Winnipeg on May 11 almost with a sense of guilt since the flood was almost at its height, though our arrangements had been made many weeks before there was any thought of flooding. In New York the newsreels were showing views of the Red River rampant and the Times carried the story on the front page so that no one meeting us needed to ask the location of Winnipeg. When we returned on May 27 the crest of the flood had passed, but its effects were only too evident. We could appreciate under what strain the doctors and nurses of Winnipeg had carried on through those grim days.

On the Functioning of the Red Cross Blood Bank During the Manitoba Flood of Spring 1950

The Rise

About the last week of April it became apparent that the state of the Red River would cause considerable trouble because of a combination of various climatic conditions. It was anticipated that flood levels in Winnipeg would exceed those of '48. Because of uncertainty as to how the new Red Cross building would be affected and whether or not the high pressure boilers would be put out of action it was decided at a Blood Transfusion Service staff meeting on May 4th, that the Nursing Department should work extra shifts in order that sterilized equipment of all types might be stockpiled to cover a possible three weeks' complete lack of autoclaving facilities.

Flood waters during the next two weeks rapidly came northward, causing complete evacuation of various towns between the United States border and Winnipeg. The people of these towns came to Winnipeg and with them came hospital in-patients. As a result, overcrowding in the Winnipeg hospitals led to a decision that elective surgery should be curtailed. As a result of this, blood consumption dropped from approximately 270 bottles in the week of May 1st to 8th, to 200 bottles and 170 bottles in the succeeding two weeks. That the drop was not greater surprised many, but the continued demand for blood arose from the needs of true emergency cases and of the cases of elective surgery still being dealt with at the Winnipeg General Hospital.

On the donor side appointments had previously been made for clinics on Monday, May 8th and Wednesday the 10th. At the beginning of this particular week Manitoba Division of the Red Cross was extremely busy in attempting to deal with the many evacuees and their problems as well as with supplies essential both for the care of those evacuees and for those who were engaged in fighting the flood. The Red Cross Centre, which houses both the Division offices and all parts of the Blood Transfusion Service, thronged with tired and muddy flood workers and with Red Cross volunteers. It was suggested that the two clinics mentioned should be cancelled, but announcements over the radio and in the press to the effect that the clinics would go on were made at my request and that better than 50% of the required number of bottles were collected at each clinic is a remarkable example of good faith on the part of the donors.

The decision had now to be made whether or not to carry on making appointments for future clinics. Because of the marked dislocation of ordinary life in the city, because of the fact that so many were engaged in flood work and because of the anticipated drop in blood consumption, it was decided by the Provincial Donor Panel Com-

mittee, the Donor Panel Organizer and myself that it would be best not to attempt continuance of the clinics and this opinion was also held by Dr. W. S. Stanbury, who had by then arrived in Winnipeg. Over Dr. Stanbury's signature a telegram was therefore sent to the Vancouver, Calgary and Edmonton Depots on May 11th alerting them to increase their clinics to provide for probable requests for blood from the beginning of the following week onwards. It was also felt that an appeal by these Depots to their committees might serve to augment their donor panels.

The Flood

From this period onwards blood was sent from the various depots in amounts indicated in the following table. Because even in the last week of May the consumption did not fall below 150 bottles it was decided to ease the burden being carried by the three western Depots, and requests were therefore sent to the Hamilton Depot in the latter part of the period.

Edmonton	Calgary	Vancouver	Hamilton	Grand Total
	May 18 40			
May 16 36	May 20 10			
May 20 78	May 25 50	May 20 48		
May 26 75	May 30 46	May 31 39	June 1 55	
June 3 83	June 2 34	June 5 48	June 6 87	
272	180	135	142	729

Because the amount of blood available in the bank was thus maintained at an adequate level no request by the hospitals was not met in full. Certain phases of the Depot's activities were, however, carried out under difficulty. Firstly, because of the gross overloading of telephone circuits, hospitals experienced delays amounting to hours in endeavouring to get through to the blood bank. This was especially the case when Divisional flood relief activities were still located in the Red Cross Centre and the position eased tremendously when a large Flood Relief Headquarters was set up in the basement of the Civic Auditorium. It was, however, easy enough for the Depot to telephone out to the hospitals and, therefore, telephone calls were put through hourly to all hospitals day and night so that both sides could rest assured of a rapid response to a call for blood.

Actual pick up of specimens and delivery of blood was, in the case of certain hospitals, an exciting and difficult procedure. Especially was this the case with St. Boniface Hospital and with Concordia Hospital. Nevertheless, despite difficulties of driving through flooded roads and over bridges aswirl with rapidly running flood waters the transport drivers never failed to make their objective and the position was later eased by evacuation of the most seriously affected hospitals.

Throughout all this time several of the Blood Transfusion Service staff, essentially administrative and nurses aides, had been released to do other flood work, and it was frequently commented that such a nucleus of disciplined and uniformed girls made a great contribution to the flood work, and did much to enhance the reputation of the Red Cross. At the Depot the technicians stood steadfastly at their posts. The Nursing Department continued to process and sterilize equipment and the Plasma Laboratory carried out its usual, although somewhat lessened, work.

The fate of the building was still in question and plans were made to cover complete power loss and total flooding. Briefly, the first stage would have been an extra power line, the supply of which would have a top priority in case of power failure. The second phase covered flooding of the Depot and, in this case, all city hospitals except the Winnipeg General Hospital, would also be out of commission. A small nucleus of the Blood Transfusion Service with essential equipment would then move to the Pathology Department of the Winnipeg General Hospital and carry on their work there. The remainder of the team would take all necessary equipment and move to the laboratory of the Brandon Mental Hospital, whence they would supply those hospitals in the western part of the province which had patients evacuated from Winnipeg.

Such drastic steps did not have to be taken, firstly, because the construction of the Depot proved adequate and only a very small amount of seepage had to be dealt with, and secondly, the crest of the flood waters came just before inundation of a major part of the city occurred.

Again it must be emphasized that, despite mass evacuation of Winnipeg's hospitals, the call for blood continued and, even in the week of May 25th to 31st, in which the demand was lowest, the weekly figure reached was approximately 160 bottles, and this may be compared with the highest figure so far reached in Winnipeg of about 325 bottles in the week of March 17th to 24th. Taking, therefore, 300 bottles as an average week, the demand never fell below 50% of the usual consumption.

Apart from the routine of the Depot, a Mobile Resuscitation Unit was set up and consisted of a panel truck with a bed and all equipment necessary to give, by cut-down if needed, emergency transfusion and other "shock" treatment. That this unit was not employed is a reflection of the almost incredible lack of casualties among the thousands of dike workers. Finally, the Donor Clinic was prepared to act as a 20-bed transit hospital and was held in reserve by the overall Medical Committee against extreme need.

The Fall

With recession of the flood waters, return to normal activities of the city hospitals was achieved in a remarkably short space of time. One reflection of this phase which followed rapid return of

evacuated patients and a lifting of the ban on elective surgery was the rapid rise in blood consumption which occurred. From about 160 bottles in the last week of May the jump was to 264 bottles in the first week of June.

Such a marked rise was anticipated and in the last few days of May, towards the end of the flood crest, plans for resumption of the donor clinics were made. The first full clinic was held on June 7th, and thereafter the normal schedule was followed. There had been several offers from towns in rural Manitoba that a mobile clinic should take blood from them to aid the citizens of Winnipeg, and on June 16th, 180 donors from Neepawa were bled.

Return to normal working conditions was free from incident and donor response was not far short of the previous average level. To meet an increased demand from hospitals, probably due to an accumulation of cases for elective surgery, clinic numbers had to be augmented somewhat and, for a time, the bank was working on a very small margin. All demands for blood were, however, met despite this remarkably rapid rise in consumption.

Comment

I believe that I am correct in saying that this is the first time that a depot has had to suspend the bleeding of donors and the incident has thrown into sharp relief one of the major features of a National Transfusion Service.

Supported by other depots, any one centre can carry on the vital job of supplying blood to an area so affected, a supply which would be most difficult and which would probably prove inadequate under any other scheme. The hospitals and the medical profession had many worries during this trying period, but they did not have to worry about blood because it was always there.

With a National Transfusion Service the individual donor gives with the ideal that his blood will succour a fellow citizen, and this is entirely independent of the arbitrary distinctions of city, town, or province, as well as race, color, or creed. The Red Cross Transfusion service in Canada is expanding and will operate through the whole of the Dominion before many years have passed. Once this has been achieved Canada will have a service scarcely to be rivalled by any other country in the world.

CECIL HARRIS, B.Sc., M.D., M.R.C.P.
Provincial Medical Director.

June, 1950.

"The Other Side of the Fence"

J. Brener, M.D.

Dedicated to: Ruth, my night nurse, who can now lay claim to the signal achievment of having tormented me with the one and only "enema" of my life time. And who by her persistent snoring, kept me awake the better part of the night, thereby spurring me on to my greatest literary efforts in a blow by blow record of my impressions on "the other side of the fence".

Foreword

When the ordinary individual undergoes surgery, the incident is either soon forgotten or becomes a topic for discussion wherever people gather. But when a character like myself, always dishing it out, subjects himself to the insults of surgery, the why's and wherefore's of all have to be satisfied. To avoid monotonous repetition, what follows will remain a true record of my story before and after.

The affliction which checked me in was a hernia. Everybody was now most curious to know just when could I have momentarily lost my reason and done work strenuous enough to bring on this condition. The truth of the matter is that while replenishing the supply for my liquor cabinet, I was carrying a case of whiskey and experienced a pain in the groin. Not wishing to drop my precious cargo I struggled in a jack-knife position from car to house, and on reaching my destination found that I was not only the possessor of a case of whiskey but a nice little hernia to boot. I could now follow one of two courses. The first was to resort to a truss, subjecting myself not only to the nuisance of the contraption, but also to the ridicule of my confreres. The second was to have it repaired surgically. I chose the latter, and so my story begins.

I was admitted to the hospital and on the way up as a matter of habit, checked myself "in" on the physician's board, realizing suddenly that tomorrow at this hour I would for the only period as far back as I can remember be "in" and "out" at the same time.

After being escorted to my room with my goods and chattels, I commenced to get organized, but arriving on the scene is the "Barber of Seville", and believe me it was the one time in my life that I was in dire fear of losing my prize possession. He reminded me of the "Hunchback of Notre Dame". Being the honored candidate of the morning slate, I was foolish enough to expect special consideration. But not this baby. He mumbled something about being behind in his schedule and instead of nursing his razor slowly along, as I would have preferred, he swished across in one clean sweep. I again tried pleading with him as he approached his royal highness "Sir Jonathan Henry". I drew his attention to the calamity that

would ensue from a slip of the wrist in this direction, and with that I shut both eyes and left my destiny in his hands. When I felt his mission ended, I spoke, and when no change in my voice could be discerned, I knew that all was left intact and that I could safely open my eyes again.

By this time my equanimity was somewhat disturbed and for the necessary pepping up I proceeded to empty the contents of a bottle of whiskey which I had reserved for this occasion. As I was in the process of quietly getting high, there was a clamor from several quarters that I receive my rightful dues on a platter containing a can of soap suds and the garden hose. I had no desire of becoming Professor R. Suppwards overnight, so I did not accede to their demands, and this decision I later on regretted. I am now firmly convinced that a rehearsal at this stage would have been good basic training for my ordeal ahead, of which I will have more to say as I get on with my story.

I still had my directives to complete before retiring for the night. To be treated as a routine patient was out as far as I was concerned. We had a gentlemen's agreement that opinions expressed by myself would receive proper hearing, and that at all times my wishes were to be respected. So with that before me, I set forth:

I insisted on intravenous Pentothal Sodium as my inducer. Any complementary anaethesia was left to the discretion of my anaesthetist. At the termination of surgery my lungs were to be hyperventilated with pure oxygen.

To my surgeon my first and foremost specification was that my hernia was LEFT sided. The spectacle of having the wrong side explored haunted me sub-consciously. I had been the exasperated witness of several of these inexcusable mishaps.

The skin was to be repainted prior to the incision, and sterile wound towels were to exclude all skin. As I was prone to forming "keloids", a small incision was preferable. The two nerves often incorporated with the External Oblique were to be identified and left intact. The small penrose drain was to be the cord retractor. A rent in the Transversalis Fascia if present was to be repaired. If the hernia was direct, it was not to be opened but transformed into an indirect one and ligated as high as possible. The operation was to be essentially a herniorrhaphy and the procedure of castration often done to obtain a more solid repair was not to be entertained. Fascia to fascia with no red meat intervening was to be the basis of repair. Chromic catgut was to be the suture of choice. Silk was definitely out. Another paint job before closing concluded my directives. I was most happy when later on I was informed that they were all followed to a "T".

The fateful morning arrived and with due ceremony, I was packed away on the cart and whisked up to the operating rorm. The nursing staff was lined up to greet me and appeared to be enjoying themselves at the sight of the oncoming spectacle. Sister shook my hand and wished me a speedy recovery. A week later she took credit for my progress, because of her special prayers. For all this I thanked her. I continued my journey and on reaching my destination, shifted on to the table. The whole routine was most familiar to me, so with the stretching out of my arm for the anaesthetic I knew the time had come and I was ready for the "kill".

My first sensation going under was that of having one too many at a party. This was followed by a feeling of swinging through air and that was all. It was simple and most wonderful. My next recollections were on awakening in my ward. I could hear familiar voices exhorting me to speak. I now realized I was coming to, and I was anxious to show an interest in what was to follow. This, however, was not to be. The pain was excruciating and a liberal dose of morphine relieved it and cut off the higher centres for the rest of the day. However, before dozing off, I called home to inform my better half of what was going on. I was in no mood for a lengthy discourse, so when she answered I decided on the shortest way out by resorting to three choice words taken from the vocabulary of my forefathers, i.e. "oiy, oiy, oiy". From this enlightening conversation she was able to conclude that the operation was over, that I was awake, and that I was not too comfortable. This task completed, I settled back and fell asleep.

I awoke hungry and thirsty. Six chocolate eclairs and a dozen Japanese oranges constituted the diet for the day. There were no repercussions until the following night and then it all back fired. It seemed that within my inner sanctum a "war" was in the making. One was mad at the other. The Jappies were throwing spit balls at the eclairs and vice versa. My tummy was distending. The dreaded "gas" pains were increasing in severity. The hour for decision had now arrived and I gave my nurse orders to prepare for operation "enema".

The battlefield was to be the side of the bed, the position the left lateral with moderate jack-knifing and the ammunition a two-four-sixer: i.e. two parts magnesium sulphate, four of glycerine and six of water. The rational of the glycerine I could never see unless it was to preclude this meal from freezing. With all set for action, she gently started the "balls" rolling.

My immediate impression was that virgin ground was being broken by using a douche nozzle instead of a fine rectal one. Assured of the contrary, I relaxed somewhat. That I was most uncooperative goes without saying. She had considerable difficulty finding her target for the night.

She would manage to get in and I would cough it out. From repetition of this manoeuver I was certain to wind up with a sore throat in the rear end. This would only add to my other trials and tribulations. With final instructions to hang on as long as possible she released the gun. After accepting about a third of this "concoction", I began to feel as if my pants were on "fire". I called an immediate halt to proceedings and in the invalid's hesitant gait, and somewhat stooped in posture, I am making a bee line for the "can" and am I in trouble.

Too modest to resort to a bed pan, I am shuffling along towards my objective. Reaching the middle of the hall, I manage to get stranded between bed and "biffy" and am suddenly seized with a terrific stitch in my wound which forces me to bend forward. But I also have a tank full of anti-freeze in my rear end which may become a gusher at any moment, which if it would leak out amongst the profession, would disgrace me for life. Well, I will end the suspense. I finally made it. The round was long and for a while I thought I'd never hear that gong go. I struggled back to bed somewhat weary but all "pooped" out.

Now anybody would conclude that this was punishment enough for one man for one night. But what happens to me before morning only happens to dogs. I am aroused from a deep slumber when my neighbor develops a state of confusion, wanders into my room in the dark of night and silently empties his bladder in my clothes closet. In my excitement, I demanded to see his registration card and questioned him as to the propriety of the closet. He calmly replied that it was all yourn (urine). The nurse on her toes charted it as a case of mistaken identity. He mistook my closet for the "John".

Nothing eventful happened in the days that followed. On looking back I have come to some definite conclusions:

Every doctor should be operated on early in his career. It will make for more sympathy and give him some idea on what his future victims will be up against.

Every nurse should receive similar treatment and be tendered the worst nursing care possible. This harrowing experience will leave her with an everlasting impression on how not to handle carved up human remains.

That for induction of anaesthesia, intravenous Pentothal is tops. There is nothing to touch it.

In conclusion, I must confess that except for a few grim moments, it was all most enjoyable. I wouldn't have missed it for anything. On the other hand, it will be after considerable cogitation and much hesitancy before I again present myself on "the other side of the fence".

Reports and Comments on the Red Cross Blood Bank, June, 1950

Brevity is the soul of wit and my previous reports upon the activities of the Red Cross Blood Depot have been sufficiently detailed to give those sufficiently interested to read them an idea of the manner in which the bank is used by the various hospitals.

The essential features are that the biggest consumers of blood include the General Hospital and St. Boniface Hospital, with Misericordia, Grace and Deer Lodge Hospitals as runners-up. Between them these five hospitals take more than three-quarters of the total and, although this distribution will be modified somewhat when Brandon and Fort William come fully into the picture, the "Big Five" will still take by far the lion's share.

The other major factor which I would once more venture to bring before you is that three bottles of blood are still being issued from the Depot for every two bottles actually used. If the "Big Five" alone are considered, seven bottles are issued by the Depot for every four used. I reiterate my belief that this figure is excessive and certainly is much above that holding good for other centres where about one-third more blood is issued than is actually used. The inevitable conclusion is, therefore, that insufficient thought is being given by some to the ordering of blood and the practical result is to make difficult the work of keeping at all times an adequate reserve in the Blood Bank. This difficulty could, of course, be overcome simply by taking more donors and in this way there would be a greater surplus of blood available for processing into plasma. Such a policy would, however, place a great strain upon the donor panel and, bearing in mind the doubling of blood consumption in the city since the service began, it would sooner or later lead to depletion of the available donors. The alternative is for physicians and surgeons to give more thought to the ordering of blood and it is but in their own interests that they should do so.

As a summary of our activities during June the following table is given.

Elective and Urgent

Issued	Used	Returned Unused	No. of Transfusions
1839	1060	779	626

Emergency

Used	No. of Transfusions
114	73

The grand total was, therefore, 1174 bottles of whole blood and it is interesting to note that, during the same period of time, only 26 bottles of plasma were used. It seems likely that the use of plasma as the initial treatment in cases of shock and haemorrhage is being neglected. While blood is, of course, superior in cases of haemorrhage, plasma is still of high value and, indeed, is probably preferable in cases of shock unaccompanied by loss of blood. More use of plasma in such cases would relieve the drain upon the stocks, never abundant, of Group O, Rh Negative blood.

Again, may I address every medical man in the Province and ask him how many blood donors he has recruited for the community bank during the last month?

Cecil Harris, B.Sc., M.D., M.R.C.P.,
Provincial Medical Director.

BOOK REVIEWS

Clinical Proceedings of the First Clinical ACTH Conference, edited by Dr. J. R. Mote, is a compilation of 52 papers given in Chicago last autumn, when, for the first time, investigation in every branch of practice came together to exchange information and compare notes.

It is becoming increasingly clear that adrenal cortical function is involved in many disease syndromes, although just how many is still uncertain. The range of investigation has been wide, the amount of work done has been immense, and the discoveries resulting therefrom have been epoch making. The spectacular results of Hench and others have opened a whole new idea of the mechanism of a large group of diseases. It introduces a new biochemical and physiological approach to the understanding of morbid processes.

In this volume of over 600 pages one can read all that is authentic to date. It gives the results of the use of ACTH in disorders of every system. It is essentially a progress report, not a final evaluation. But inasmuch as the matter is of great and increasing importance it would seem wise for practitioners in every branch of medicine to familiarize themselves with the present status of the subject. Before long, ways will be found to produce ACTH in larger quantities and at less cost. It will then come into more general use, and those who are to use it should be familiar with its actions and indications. Nowhere else will they find so much information within the compass of a single volume.

Clinical Proceedings of the First Clinical ACTH Conference. 607 pages. Blakiston Company, Toronto. Price $6.00.

Aids to Diagnosis

Recently Frank W. Horner Ltd. released a manual entitled "Aids to Diagnosis". This useful little book was prepared primarily to assist in the correlation of clinical and laboratory findings. It is in petto a very complete laboratory manual which includes the techniques of examination, tables of normals, significance of departures from normal and so on. In size it is small enough to fit the pocket and could very conveniently occupy a pocket of every intern and technician. Doctors will find its terseness time saving and its instructions simple. To procure a copy write to Frank W. Horner Ltd., 950 St. Urban Sreet, Montreal. It is free.

Among the Doctors, by Alfred Cox, formerly Secretary of the British Medical Association. London, Christopher Johnson, 12s 6d net.

Out of the fulness of a life spent for and among doctors, Dr. Cox has written a book which might justly be called a social history of the last eighty years. That suggests something ponderous, but the book escapes by virtue of the many anecdotes and the keen observations on men and movements. The names of Keir Hardie, General William Booth, Lord Lister, Rutherford Morison, Lloyd George, Sir Victor Horsley, Madame Patti, Neville Chamberlain, Lord Dawson of Penn, Lord Monynihan, Lord Horder and Aneurin Bevan figure in the pages.

Perhaps because he was the son of a Presbyterian, he was foreordained to be an organizer and secretary. He came into medicine the hard way by serving as an unqualified assistant while studying for his matriculation from Edinburgh, and for his four years medical course in the University of Durham. In that time he saw the seamy side of contract practice and club practice under the Friendly Societies. Soon after starting in Gateshead, he organized the first medical society there, was elected to the municipal council and became prominent in the British Medical Association in the north of England. In 1908 he was appointed Deputy Medical Secretary of that body.

He found himself in the heated struggle between the doctors and Lloyd George, who wished to establish his scheme of National Health Insurance. When the secretary of the British Medical Association resigned in 1911 to become Vice-Chairman of the National Health Insurance Commission, Cox succeeded him and held the post for twenty years.

As Secretary of the B.M.A. Dr. Cox had much to do with formulating policy. The British Medical

Association is not confined to the British Isles, and in 1925-26 he made an extensive tour of South Africa to establish solidarity among the doctors there. In 1924 the Winnipeg doctors, through the Canadian Medical Association, invited the B.M.A. to hold its annual meeting in Winnipeg. Sir Jenner Verrall, Chairman of the Representative Body, and Dr. Cox were sent to Canada to review the situation. Cox was delighted with Canada and felt quite at home in Winnipeg. He relates the story of a picnic at Sandy Hook, on Lake Winnipeg, when after lunch there was a sing-song in which everyone joined, led by two or three of the leading consultants in their shirt sleeves, one of them a noted surgeon with a cornet. The 1924 visit was followed by the 1930 meeting of the B.M.A. in Winnipeg—"a triumphant success". To Dr. Cox the outstanding feature of the meeting was the pageant and procession arranged by Dr. Speechly.

Dr. Cox's political opinions have changed from the time when as a young man he was so impressed with the earnestness of the disciples of Keir Hardie that he joined the Independent Labor Party. Now he believes that the British people are being "equalized downwards" and made into a spoon-fed nation, taught to look to the State for everything.

Anyone who is interested in the vexed question of the best means of providing medical care to everyone—and who is not—will find an honest opinion in Dr. Cox's book.

Ross Mitchell.

A Refresher Course for General Practitioners, conducted by 41 authorities, on a corresponding number of topics is, in essence, the Modern Treatment Yearbook. This useful annual volume has long been popular. The articles are "concise, pithy, lucid and practical", and are planned for the busy doctor whose time for reading is limited by the pressure of his duties. Here is the "Programme":

The Modern Treatment of Carcinoma of the Breast—Sir Stanford Cade; An Approach to the Investigation of the Subfertile Couple—C. S. Lane-Roberts; The Modern Treatment of Latent Amoebiasis—A. L. Gregg; Tuberculosis Lymphadenitis—Rupert Corbett; The Aetiology and Modern Treatment of Achlorhydria—James Ronald; The Early Diagnosis and Treatment of Carcinoma of the Rectum—W. H. C. Romanis; Contemporary Skin Hazards in Industry—Henry C. Semon; The Modern Treatment of the Retropulsed Lumbar Intervertebral Disc—J. R. Armstrong; Modern Trends in the Treatment of Pulmonary Tuberculosis—William C. Fowler; Various Forms of Conjunctivitis and their Treatment—R. Lindsay-Rae; Diabetic Emergencies—Wilfrid Oakley; Pulmonary Embolism; its Early Diagnosis and Treatment—Samuel Oram; The Care of Old Age in the Home—J. H. Sheldon; Head Injuries Due to Road Accidents—Lambert Rogers; The Value of Drugs in the Treatment of Heart Disease—T. Jenner Hoskin; The Aetiology and Modern Treatment of Amenorrhoea—Hector R. Maclennan; The Third Molar—Gerald Jack; The Aetiology, Prevention and Treatment of Retained Placenta—Kathleen M. D. Harding; The Aetiology and Treatment of Paroxysmal Tachycardia—Courtenay Evans; Modern Treatment of Fracture of the Os Calcis—Alexander Miller; Detachment of the Retina—W. J. B. Riddell; Chronic Otitis Media—W. H. B. Magauran; The Modern Treatment of Burns—James A. Ross; Sycosis Barbae— W. J. O'Donovan; The Modern Treatment of Hysteria in Children—Doris Odlum; Radical Excision of the Rectum without Colostomy—Ronald W. Raven; The Diagnosis and modern Treatment of Injuries of the Semilunar Cartilages—John A. McLaughlan; Aetiology and Treatment of Iridocyclitis—J. G. Milner; The Internal Fixation of Fractures of the Shafts of the Long Bones—S. A. S. Malkin; The Diagnosis and Modern Treatment of Pink Disease—Douglas N. Nicholson; Treatment of Tendon Injuries in the Hand—Frederick M. Smith; The Treatment of Pulmonary Tuberculosis in Children—Beryl E. Barsby; Emergency Surgery in the Neonatal Period—J. J. Mason Brown; Diagnosis and Modern Treatment of Hypertrophic Pyloric Stenosis in Infancy—Charles Pinckney; Chronic Mastitis—Amy A. Fleming; Proptosis: its Differential Diagnosis and Treatment—L. H. Savin; Pyorrhea—J. Forbes Webster; Cystitis—Ian M. Orr; The Treatment of Sydenham's Chorea—E. R. C. Walker; Modern Trends in the Treatment of Intermittent Claudication—Maurice Newman; The Treatment of Genital Warts—R. R. Wilcox.

Modern Treatment Year Book, 1949: A year book of diagnosis and treatment for the general practitioner. Edited by Sir Cecil Wakeley, K.B.E., C.B., D.Sc., F.R.C.S., F.R.S.E., F.A.C.S., F.R.A.C.S., (Hon), Fellow of King's College, London; Senior Surgeon, King's College Hospital, London; Surgeon Royal Masonic Hospital and Belgrave Hospital for Children, Editor of "The Medical Press"

Published in Canada by MacMillan Co. of Canada, Ltd., Toronto. Price $3.25.

OBITUARIES

Dr. Omer G. Hague

Dr. Omer G. Hague, of Winnipeg and St. Vital, died in Royal Victoria Hospital, Barrie, Ont., on June 10. When his home in St. Vital was flooded he waded chest-deep into the water to rescue his St. Bernard dog, and contracted pneumonia. With his wife he went to Ontario and they were on their way home when he collapsed on the train.

He was born in Toronto and graduated in Medicine from the University of Toronto. He received a diploma of Radiology in 1925, having worked under the late Dr. Gordon Richards. He came to Winnipeg in 1928, and has practised radiology. He was a Fellow of the Royal College of Physicians and Surgeons, a member of Windsor Lodge, A.F.&A.M., the Scottish Rite and Khartum Temple of The Shrine, and the Kiwanis Club. He was a member of St. Luke's Church. He is survived by his widow. Burial was in St. James Cemetery, Toronto.

Dr. Frank Woodside Boyd

Dr. Frank Woodside Boyd died on July 10 in the Winnipeg General Hospital. Born at Portage la Prairie 47 years ago, he graduated in medicine from the University of Manitoba in 1927, and practised in Winnipeg until his death. He was active in the Riverview Community Club. He is survived by his widow, a son and daughter.

Dr. M. Ellen Douglass

Dr. M. Ellen Douglass died at her home in Winnipeg on July 11. Born in Stanley, N.B., she was educated at Edgehill Anglican Church School, Windsor, N.S., and at the University of New Brunswick. Her course in Medicine was taken at the University of Toronto and after graduation there she studied in Baltimore, New York and London.

She started practice in Saint John, N.B., then came to Winnipeg in 1909, where she practised continuously save for the war years. In the First World War she became an officer in the Royal Army Medical Corps, and served overseas with the Women's Army Auxiliary Corps.

In addition to an extensive medical practice she took a leading part in women's organizations. She was a president of the Canadian Federation of Professional and Business Women's Clubs and represented that body at an international meeting held in Budapest in 1938. She was president of the Winnipeg Women's Canadian Club, and in 1950, was made a life member of the University Women's Club. In 1946 she was elected Honorary President of the Federation of Medical Women, and in 1948 while serving as provincial commissioner of the St. John's Ambulance Brigade she was given the title of Commander Sister of the Order.

An able public speaker, she taught by precept and example the values of cheerfulness and public service.

Dr. B. A. Victor . . . An Appreciation

DR. BENJAMIN AARON VICTOR, of Winnipeg, died on June 6th, 1950, in Winnipeg General Hospital after a lengthy illness. Born in Szlobin, Province of Minsk, Russia, in 1892, he arrived in Canada in 1911. Graduating in Medicine from the Manitoba Medical College in 1919, he practiced in Verigin, Saskatchewan, until 1923. He then spent one year in post-graduate work in London, England, and upon returning to Canada settled in general practice in Winnipeg. He served on the staff of the St. Joseph's Hospital during the twenty-five years of his practice in Winnipeg.

The death of Dr. B. A. Victor marks the passing of a colorful figure from Winnipeg's North End scene. For a quarter of a century he pursued a very full and energetic life in the dual capacity of a busy medical practitioner and active worker in the field of the humanities. He embodied all the characteristics of the typical family physician, and, as time went on, his ready smile and encouraging advice became the "sine qua non" to his many patients, and in turn he repaid them for their confidence by consecrating his professional life to the healing of a large cosmopolitan section of the New Canadians settled in the North End of the City. Selflessly and unselfishly he served them all, rich and poor, young and old, white and colored, Jew, Slav and Anglo-Saxon; and until his illness finally forced him to bed, just a few short weeks before his death, he continued his regular calls on his patients.

Just as vigorously and devoutly did Dr. Victor pursue his other avocation—the spreading of the gospel and philosophy of enlightenment. He relentlessly and uncompromisingly rebelled against any and all social injustices and forever championed all righteous causes. This had won for him a place amongst the leaders of the progressive organizations in the North End whose ideals and aims he ceaselessly preached, sometimes in the face of almost insurmountable difficulties. His motto may well have been "Nihil humanum mihi alienum est."

Dr. Victor's passing is mourned alike by those who looked to him for sympathetic professional succor as well as by those who benefited from his spiritual guidance.

Sic tibi terra levis!

B. J. Ginsburg.

Manitoba Medical Association

(Canadian Medical Association, Manitoba Division)

Tentative Annual Meeting Programme

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Guest Speakers

Dr. J. W. Abbiss, Assistant Professor of Pathology, Dalhousie University, Halifax.

Dr. H. B. Atlee, Professor of Obstetrics and Gynaecology, Dalhousie University, Halifax.

Dr. F. W. Jackson, Director of Health Insurance Studies, Department of National Health and Welfare, Ottawa.

Dr. Norman Gosse, President, Canadian Medical Association.

Dr. Victor Johnston, President, Section of General Practitioners, C.M.A., Lucknow, Ont.

Dr. Leonard T. Kurland, Department of Epidemiology, Johns Hopkins University, Baltimore, Md.

Monday, October 2nd

Evening

6.00 President's Dinner to Retiring Executive of the Manitoba Medical Association, Vice-Regal Suite.

8.00 Executive Committee Meeting, M.M.A., Windsor Room.

Tuesday, October 3rd

Morning

Royal Alexandra Hotel:

8.30 Registration.

9.00 to 11.30 St. Boniface Hospital: Clinical Session.

Noon

Royal Alexandra Hotel:

12.00 Registration.
Scientific Exhibits.
Commercial Exhibits.

Afternoon

Royal Alexandra Hotel:
Scientific Session, Crystal Ball Room.

2.00 Dr. D. L. Scott, Winnipeg, Chairman.
Carcinoma of the Sigmoid and Rectum,
Dr. Norman H. Gosse, Halifax.
Present Status of A.C.T.H. and Cortisone,
Dr. L. G. Bell, Winnipeg.
Deafness,
Dr. Walter Alexander, Winnipeg.

3.15 Intermission:
Visit Scientific and Commercial Exhibits.

3.30 Dr. Cherry Bleeks, Winnipeg, Chairman.
Chronic Right-sided Pain in Women,
Dr. H. B. Atlee, Halifax.
Skin Manifestations as an Aid in the Early Diagnosis of Internal Disease,
Dr. Saul Berger, Winnipeg.
Premarital Blood Tests,
Dr. L. P. Lansdown, Winnipeg.

6.00 Dinner
Royal Alexandra Hotel, Main Dining Room.
General Practitioners' Association of Manitoba.
Guest Speaker: Dr. Victor Johnston, Lucknow.

Evening

Royal Alexandra Hotel, Crystal Ball Room.

8.00 Business Session, General Practitioners' Association.
Other Sectional Meetings.

« « MENTAL STIMULATION AND READY KNOWLEDGE » »

Winnipeg, October 2, 3, 4, 5

Headquarters First Floor

Royal Alexandra Hotel

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Wednesday, October 4th

Morning

Royal Alexandra Hotel:

8.30 **Registration.**

9.00 **Scientific Session, Crystal Ball Room.**
Prof. I. M. Thompson, Winnipeg, Chairman.
Cerebral Vascular Accidents,
Dr. Dwight Parkinson, Winnipeg.
Observations on Human Abortion Ova,
Dr. I. W. Monie, Winnipeg.

10.30 **Intermission:**
Visit Scientific and Commercial Exhibits.

10.45 Dr. M. R. MacCharles, Winnipeg, Chairman.
Cytology in the Diagnosis of Cancer,
Dr. J. W. Abbiss, Halifax.
Fractures of the Shaft of the Radius and Ulna,
Dr. E. S. James, Winnipeg.
Vagotomy in the Treatment of Duodenal Ulcer,
Dr. K. R. Trueman, Winnipeg.

Noon

Royal Alexandra Hotel:

12.30 **Luncheon,**
Guest Speaker:
Dr. Norman H. Gosse, Halifax,
President, Canadian Medical Association.

Afternoon

Royal Alexandra Hotel:

2.00 **Annual Business Session, Crystal Ball Room.**
Presidential Address.
Annual Committee Reports.
(Voting by Ballot until 5 p.m. Thursday).

Evening

Royal Alexandra Hotel, Crystal Ball Room.

8.00 **Annual Business Session (Continued), Crystal Ball Room.**

Thursday, October 5th

Morning

Royal Alexandra Hotel:

8.30 **Registration.**

9.00 **Winnipeg General Hospital: Clinical Session.**

Noon

12.30 **Luncheon, Winnipeg General Hospital.**
Guest Speaker: Dr. F. W. Jackson, Ottawa.
Subject: Federal Health Grants.

Afternoon

Royal Alexandra Hotel:

2.00 **Scientific Session, Crystal Ball Room,**
Dr. Roy Martin, Winnipeg, Chairman.
Natural Childbirth and other Factors in Obstetrics,
Dr. H. B. Atlee, Halifax.
Speech Mechanism and the Repair of Cleft Palate,
Dr. E. W. Pickard, Winnipeg.

3.15 **Intermission:**
Visit Scientific and Commercial Exhibits.

3.30 Dr. J. D. Adamson, Winnipeg, Chairman.
Bantis Disease,
Dr. J. W. Abbiss, Halifax.
Hand Injuries,
Dr. N. P. Merkeley, Winnipeg.
Multiple Sclerosis in Canada and the United States, with special reference to Winnipeg,
Dr. Leonard T. Kurland, Baltimore, Md.,
Dr. M. Bowman, Winnipeg.

Evening

Royal Alexandra Hotel:
Reception:

6.30 **Aperitifs, Tea Lounge.**

7.00 **Annual Dinner, Main Dining Room.**

9.00 **Dancing, Crystal Ball Room.**

Ladies' Programme

Under the Chairmanship of Mrs. D. L. Scott, the Ladies' Committee is preparing a programme that will be of interest to all ladies attending. Full details of the activities may be obtained at the Registration Booth in the Royal Alexandra Hotel. Please register as early as possible.

« « WILL BE THE REWARD OF ALL THOSE ATTENDING » »

SOCIAL NEWS

Reported by K. Borthwick-Leslie, M.D.

Congratulations to Dr. George Sisler, assistant physician at the Winnipeg Psychopathic Hospital, who has been awarded a bursary and is continuing a year's work at the Morton Clinic, University of Louisville, Kentucky.

♦

Dr. and Mrs. Harold Blondal sail shortly for London, Eng. Harold has been awarded a Fellowship in Cancer Research and will continue his studies at the Royal Cancer Institute. Prior to sailing he is taking over Dr. Glen Gibson's practice in Tamiskaming, Quebec, while Glen holidays in California. The best of all good luck to Harold and Pat.

♦

Dr. and Mrs. Bob Beamish are back from a month's motoring holiday on the West Coast. In transit Bob attended the American Heart Convention and a short post-graduate course at the San Francisco University of California.

♦

Dr. Asa Kristpansson-MacDonell, and husband Dr. Jack MacDonell have sailed for London, where both will do post-graduate work.

♦

Dr. and Mrs. Frank Stuart and sons have also arrived in England, where Frank will attend the Sixth International Congress of Radiology in London. Reports state that they appreciate living in a home again after Wildwood's disruption.

♦

Dr. Isobel McTavish was elected President of the "Clan McTavish" at their annual meeting at Clear Lake. She succeeds Dr. G. B. McTavish in the presidential chair.

♦

Dr. and Mrs. Hugh K. Henderson will make their home at 1189 Beach Drive, Victoria, B.C., after a sojourn of six months in Florida.

♦

Dr. and Mrs. Aaron Kastner have returned from their wedding trip in the Laurentians and are residing in Montreal where Dr. Kastner is on the staff of the Jewish General Hospital.

Congratulations to Dr. Maxwell Bowman, who has been certified by the American Board of Preventive Medicine and Public Health, and appointed a member of the Founders Group.

♦

Dr. Jan Hoogstraten has flown to England to deliver a paper on Leukaemia to the International Congress of Haematologists, at Cambridge University.

♦

We are sorry to say good-bye to Dr. Dorothy Barnhouse, Anaesthesiologist at the General Hospital, who has accepted an appointment on the staff of the University Hospital, Edmonton. Good luck, Dorothy.

♦

Sincere sympathy to the relatives and friends of Dr. Ellen M. Douglass on the loss of that wonderful doctor and friend.

♦

Born to Dr. and Mrs. Wm. Malyska at Deloraine Memorial Hospital on Monday, June 26th, 1950, a daughter (Shirley Antonia).

♦

Dr. and Mrs. J. L. M. Whitebread of Chilliwack, B.C., are happy to announce the birth of their son (Robert Frank Thomson) on July 9th, 1950.

♦

Dr. and Mrs. W. G. Newman of 339 Cordova St., are happy to announce the birth of their second daughter on July 26th, 1950, at the Grace Hospital.

♦

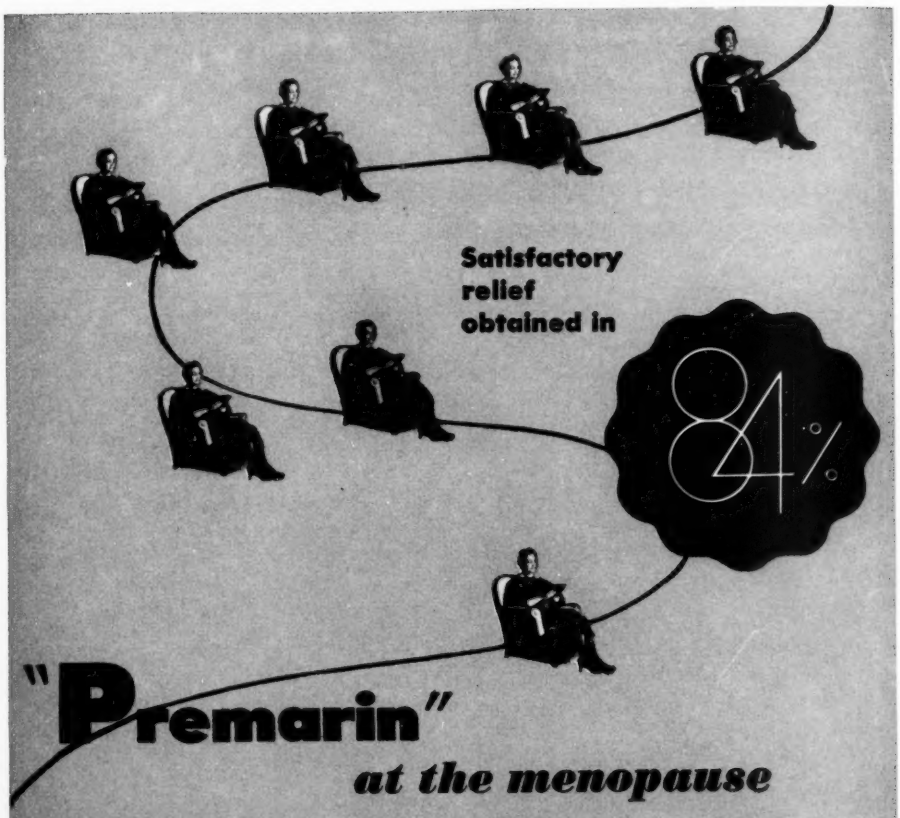
Dr. and Mrs. Stewart A. Orchard (nee Betty I. Best) of Saskatoon, Sask., are happy to announce the birth of their son (James Stewart) on June 25th, at the City Hospital, Saskatoon.

♦

Dr. and Mrs. D. W. Penner announce the birth of their third child, a son (Stanley Brian), on August 7th, 1950, at the Winnipeg General Hospital.

♦

Dr. and Mrs. Maurice Marmar announce the birth of their son (Earl Sheldon) on July 3rd, 1950, at the St. Boniface Hospital (a brother for Charles).



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This high average of successful therapy is based on clinical reports by:

Freed, S.C., Eisin, W.M. and Greenhill, J.P.: J. Clin. Endocrinol. **3**:89 (Feb.) 1943.
Fried, P.H. and Hair, Q.: J. Clin. Endocrinol. **3**:512 (Sept.) 1943.
Glass, S.J. and Rosenblum, G.: J. Clin. Endocrinol. **3**:95 (Feb.) 1943.
Gray, L.A.: J. Clin. Endocrinol. **3**:92 (Feb.) 1943.
Harding, F.E.: West. J. Surg. Obst. & Gynec. **52**:31 (Jan.) 1944.
Perloff, W.H.: Am. J. Obst. & Gynec. **58**:684 (Oct.) 1949.
Sevringhaus, E.L. and St. John, R.: J. Clin. Endocrinol. **3**:98 (Feb.) 1943.

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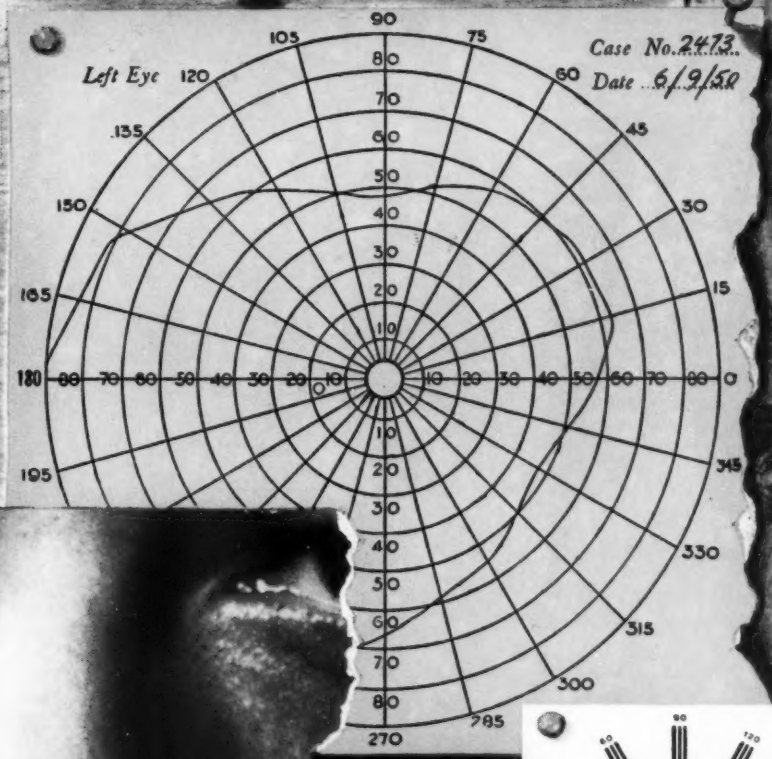

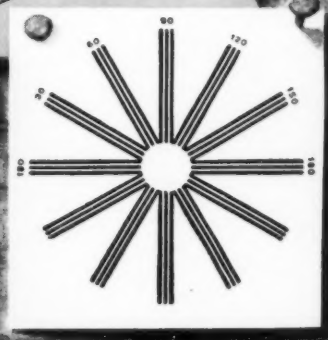

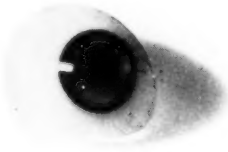

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EDITORIAL

J. C. Hossack, M.D., C.M. (Man.), Editor

An interesting point about the recent flood is the fact that a quarter of a million of people got along quite well for three weeks without the benefit of hospital facilities. There was probably little change in the number of those who ailed, and few died at home who would not also have died in hospital. From this it follows that patients can be cared for successfully at home even today when technical investigation is regarded as essential for proper treatment, and it further follows that, in normal times, many patients do not need hospital beds. To be sure it is much more convenient for a doctor to have his scattered practice gathered under one roof, and in many cases getting a patient out of his or her home is in itself a therapeutic measure. But now that the old familiar cry "Sorry, no beds" is again being heard in the land, we can help ourselves, the hospitals and the really sick by keeping at home those who need go no further to get well.

Flood Relief Fund Report

The Manitoba Flood Relief Fund has closed the campaign for subscriptions after a very generous response, firstly in Manitoba and also from other Canadian provinces, and from abroad. A grand total of $8,305,000.00 was realized. The Central Committee solicited the organization of many sub-committees in the professions, trades, labor and commercial groups and requested the medical profession of the city and province to initiate and carry out a canvass for contributions from its members.

A group met, including representatives from the officers of the Manitoba Medical Association, the College of Physicians and Surgeons, the Winnipeg Medical Society, the General Practitioners' Association, the Dean of the Medical College, and others. An organization was set up with Dr. P. H. T. Thorlakson as Chairman, Dr. S. A. Boyd, Secretary, and Dr. W. J. Boyd, Treasurer. Dr. T. H. Williams later assumed the Chairmanship. Many doctors took an active part in soliciting subscriptions in Greater Winnipeg and the province. Through the Canadian Medical Association the appeal was also passed to the various provincial Medical Associations and the committee mailed many thousands of copies of press illustrations with flood fund appeals. Many of the doctors outside Greater Winnipeg took an active part in and subscribed through local canvasses in their area.

There was received through the canvass of the medical profession and paid in by the Medical Committee to the Central Fund a total of $47,026.45. The committee has also records of subscriptions through other canvass agencies, paid by members of the medical profession, totalling $3,083.50. There was received from outside the province, through the Medical Committee, $750.00. This makes a grand total raised by the medical profession for Flood Relief of $50,839.95.

The Committee wishes to express thanks to all those who assisted in the campaign.

T. Harry Williams, Chairman.

Nominating Committee

General Practitioners' Association

The following is the list of nominations submitted by the Nominating Committee of the General Practitioners' Association and approved by the Executive of that body:

President:

Dr. M. M. Brown

1st Vice-President

Dr. Jack McKenty, Dr. D. N. C. McIntyre

2nd Vice-President:

Dr. V. F. Bachynski, Dr. J. J. Lander

Recording Secretary:

Dr. L. A. Sigurdson, Dr. Earl Vann

Corresponding Secretary:

Dr. Claire Benoit, Dr. R. L. Danzinger

Treasurer:

Dr. A. A. Keenberg, Dr. S. Malkin

Members at large (four to be elected):

Drs. Wm. Boyd, R. A. Claassen, Russell Glen Hamilton, S. Markovits, J. Winestock.

Nominations can, of course, also be made from the floor of the Annual Business Meeting.

To the Secretaries of Divisions

I have been requested to advise you of the forthcoming sickness survey which will commence shortly in most provinces, and to solicit, through you, the goodwill and co-operation of your doctors.

The purpose and technique of this morbidity study is described in an article at page 559 of the June issue of the Canadian Medical Association Journal. You will note that a representative sample of Canadian families will be visited by a lay enumerator monthly for a year, and that a variety of data on illness will be recorded. It is apparently not proposed that the enumerators shall seek confirmation of their findings by interviewing doctors, but it is desirable that physicians be aware of the conduct of the survey, and, if consulted by patients, that they should encourage them to answer the questions of the enumerators.

It is admittedly a very difficult technical procedure to accumulate accurate information on the incidence of illness in a population. The medical profession is interested in the outcome of such a survey, and I think that most individual physicians would be prepared to advise their patients to participate.

I have examined the Instructions for Enumerators and the documents on which they will record their findings. This is a study conducted by lay enumerators recording the medical facts in the exact words used by those interviewed. Interviewers are sworn to secrecy and the confidential doctor-patient relationship will not be involved.

The study is an important part of the National Health Survey, and the technique has been carefully worked out by officers of the Department of National Health, the Dominion Bureau of Statistics and the Dominion Council of Health. Details of the procedure applicable to your province will be available from your provincial Department of Health.

You are requested to acquaint your members by any means of publicity at your disposal with the information that the Sickness Survey is about to commence.

(Signed) A. D. Kelly,
Assistant Secretary,
Canadian Medical Association.

Fellowships 1951

The Canadian Arthritis and Rheumatism Society

Fellowships for post-graduate training in the Rheumatic diseases are immediately available for study at University Centres in Great Britain, the United States and Canada.

The Fellowships will be tenable for a period of twelve months, although renewal of Fellowships for more than one year will be considered. The amounts will vary from $1,500 to $4,000 per annum in accordance with the candidates' experience and qualifications.

The Society will pay the Fellows' travelling expenses from their place of residence in Canada to and from the place of training.

Fellowships will be tenable annually, July 1st. The deadline for applications will be October 1st.

Further information has been placed in the hands of Deans of Medicine or may be obtained from the Assistant Executive Director, Canadian Arthritis and Rheumatism Society, 74 Sparks St., Ottawa, Ont.

Mental Hospital Institute Meeting

The Second Mental Hospital Institute, sponsored by the American Psychiatric Association, will be held at St Louis University Auditorium, St. Louis, Missouri, October 16-19, 1950. Representatives from all types of public and private mental hospitals, schools for mental deficiency, general hospitals with psychiatric departments, state and provincial administrative offices, hospital boards of trustees, and organizations concerned with the hospitalized mentally ill in the United States and Canada are eligible to attend.

Equivalent to a post-graduate seminar, the four-day workshop will cover administration and business management, community and public relations, clinical practices and problems, and in-service education and training. Faculty co-chairmen are Drs. J. Freemont Bateman, Addison M. Duval, C. Charles Burlingame, Frank F. Tallman, Karl M. Bowman, George E. Reed, Newton J. T. Bigalow and Harvey J. Tompkins.

The attendance fee is $50.00. Advance registration should be made with Director, A.P.A. Mental Hospital Service, 1624 Eye Street N.W., Washington 6, D.C.

ASSOCIATION PAGE

Reported by M. T. Macfarland, M.D.

Canadian Medical Association Eighty-first Annual Meeting

The historic city of Halifax provided the Maritime setting for the meeting which was held from June 19-23, 1950.

General Council met in the ballroom of the Nova Scotian Hotel, headquarters for the Convention, on Monday and Tuesday, June 19 and 20. Of a possible one hundred and thirty-five named representatives, approximately eighty-six per cent attended. Official delegates from Newfoundland, the tenth division, were present for the first time.

Council deliberations were presided over by Dr. J. Harris McPhedran, and discussions were on a high level. Doctors McPhedran and Routley gave brief accounts of their visit to the second British Commonwealth Medical Conference held at Brisbane, Australia, in May, 1950. It was agreed that C.M.A. should participate in the third conference in South Africa in 1951.

Future C.M.A. Meetings

The venue for future Annual Meetings is as follows:

1951—Montreal
1952—Banff
(with accommodation at Lake Louise)
1953—WINNIPEG
1954—Vancouver
1955—Toronto (a joint meeting with the British Medical Association, and delegates from the American Medical Association).

The dates for 1950 Annual Divisional meetings were announced.

Membership

Ordinary membership figures were substantially less than in 1949, due in part, perhaps, to reversion to the $10.00 Annual Fee, and consequent increase in the joint fee collected by divisions Ten senior members were named, including Dr J. A. Gunn, Winnipeg, who was prevented from attending to receive the honour in person.

Department of Veterans' Affairs

Perhaps no item on the Council Agenda provoked such varied discussion as the accomplished fact that since April 1st, 1950, non-entitled veterans have been admitted to D.V.A. hospitals on payment of the $8.65 per diem charge. Hospitals have remained "closed," limiting the free choice of doctor by the veteran, and no satisfactory plan of payment for professional services rendered by the individual doctor has yet evolved. The matter was referred back to the Executive Committee for further study and report.

The Arthritis Survey

By resolution of the Executive Committee, C.M.A., a committee under the Chairmanship of Dr. E. S. Mills, with Doctors J. D. Adamson, R. F. Farquharson and F. S. Brien as a nucleus was constituted for the purpose of obtaining statistical information as to the facilities for the treatment of arthritis in Canadian Hospitals. Dr. Lester McCallum was selected by the Committee to conduct the Survey which consisted of visits to as many larger centres as possible in the allotted time. Co-operation with local representatives of the Canadian Arthritis and Rheumatism Society was solicited, and given, with assistance from the various hospitals and other interested personnel. Interviews elicited discussion of: (1) Questionnaire; (2) Method of medical practice in the area; (3) Magnitude of the local arthritis problem; (4) Projected plans for the future from the hospital, community and provincial point of view. The report with statistical data was made to the Executive Committee in March, and a summary was prepared for General Council. It was noted that the Committee recommendations were controversial, but they represented the unanimous opinion of all members of the Nucleus Committee. They are as follows:

1. Facilities for the management of arthritics in Canada are inadequate.

2. Diagnostic facilities for arthritic patients should be much improved in the medical wards of general hospitals.

3. Management of cases requiring prolonged care should be in a special wing of a general hospital or a special hospital for the care of the chronically ill.

4. In the case of special hospitals, these should be in close proximity to general hospitals in order that adequate services may be available.

5. The long-term management of the arthritic can, in most cases, be carried out successfully by the general practitioner provided that the advice of a special team is available from time to time for consultation.

6. The nucleus of this team should be an internist with an interest in arthritis (it is not necessary that he be a rheumatologist and it is not desirable that he restrict his interests solely to the rheumatic diseases), a physician specializing in physical medicine, and an orthopaedic surgeon.

7. Because chronic arthritis is frequently perpetuated by environmental circumstances, any general scheme for treatment should embrace social services calculated to supervise patients in their homes.

8. Adequate care of the arthritic in Canada depends primarily upon:

(a) Provision of at least 1,000 beds across Canada housed in units adjacent to general hospitals having adequate diagnostic facilities.

(b) The setting up of special teams to supervise the management of the cases and to advise the general practitioner as required.

9. Requests should be made for adequate funds to provide not only a minimum of 1,000 beds in civilian hospitals in Canada, but to meet the cost of essential ancillary services—laboratory, investigation, physiotherapy, home and institutional nursing care, social services and occupational therapy. Your Committee believes that such a policy would pay high dividends in terms of productive man hours and salvage many that are now charged against the individual, the family and the state.

Income Tax

In January, 1950, the Income Tax Committee interviewed the Minister of National Revenue concerning deductions for expenses of post-graduate education, on the encouragement of investment in retirement funds, and on taxes paid by the estates of deceased doctors. No change was reported in the attitude towards post-graduate expenses, but acceptable modification may be made with respect of retirement contributions and annuity payments —such matters are related to the discussion of pensions now before a Committee of the House of Commons. Some changes have already been made concerning taxes payable by the estates of deceased doctors. A resolution of Council congratulated the Committee on its efforts, but requested that representations be renewed on behalf of salaried physicians.

Public Relations

In addition to the preparation of the film strip "Careers in Canadian Medicine" and the new bulletin "On Call" which is directed to each member of the profession in Canada, the Committee secured professional assistance of Public and Industrial Relations Limited and Mr. Ivan MacNeil attended sessions of General Council to discuss problems in this field. No executive Committee or Public Relations Personnel can accomplish miracles without the co-operation of each and every member. It is necessary to show that the voluntary way can, and will, work. The approach to the public must be positive and sustained. Final years in medicine should be contacted, and a roster of medical speakers who will be available to give addresses to lay audiences on request arranged. The Committee will arrange to have material accumulated for such speakers to draw from, and the Assistant Secretary, Dr. A. D. Kelly, will devote more time to this important matter.

Honorary Treasurer's Report

Dr. D. S. Lewis, in the final report which he will present at this capacity, outlined the highlights of the year's business which saw decreasing revenue from investments, some reduction in Annual Meeting income and increased costs for printing of the Journal, travel and the Arthritis Survey. The surplus of $6,640.00 was considerably less than one year ago. Council approved a resolution that an expense allowance up to $25.00 daily should be made available to the President of the C.M.A. for every day he is engaged in Association work.

Committee on Economics

In an extensive recapitulation the report outlined attempts which had been made to implement the "Statement of Policy" adopted at Saskatoon in 1949, by extending coverage of the voluntary prepaid medical care plans. Following a conference of the Plans in November, 1949, efforts were made to secure a charter for Medical Services (Canada) Inc. The decision that the new body, a "holding company" co-ordinating all the prepaid plans in Canada would be transacting insurance business led to delay, and the impression was gained that it would be inexpedient to seek incorporation by a special act of parliament. Some provinces have not endorsed professionally-sponsored plans but support those offered by the "Blue Cross" organizations. The Executive Committee in March withdrew previous instructions and requested the formation of a correlating body for medically-sponsored plans. A conference in line with this latter proposal was announced for Wednesday, June 21st. The Committee also dealt with such items as extension of voluntary plan privileges to those who find the premium subscription beyond their means, methods of identifying persons eligible for government assistance; long-term study of voluntary health agencies sponsored by lay groups; non-entitled veterans in D.V.A. Hospitals; provincial health surveys; Dominion-Provincial Conference, etc. Council approved the resolution of the Executive Committee that approach should be made by the C.M.A. to the Officers of the Canadian Life Insurance Underwriters Association to discuss prepaid medical care insurance. Discussion also ensued concerning the methods of administration of any health plan, and the Committee on Economics was requested to study without delay the previously asserted policy that control be in the hands of an independent, non-political commission.

Report of the Committee on Pharmacy

Reference was made to the system of registration of all new drugs prior to sale by the federal Department of National Health and Welfare. At the request of the World Medical Association a

study was made of the necessity for the use of Heroin, and the possibility of substituting some other drug for it. A resolution of the Committee to the effect that Heroin should not be prohibited but that satisfactory substitutes might be prescribed was accepted by General Council in approving the Committee report.

Report of the Committee on Medical Education

This report dealt with such topics as Internships for Undergraduate Medical Students with General Practitioners, Physicians and Students who are Displaced Persons, Supply of Physicians in Canada, availability of Teaching Beds for Medical Schools and the Increasing Use of Voluntary Health Insurance, Recommendations from the 13th Annual Conference of Canadian Association of Medical Students and Internes to the Canadian Medical Association. Sections of the report were referred back to the Committee for further study. Council approved a resolution that provincial licensing bodies and the Association of Canadian Medical Colleges consider the possibility of issuing a "Basic Licence" for general practice. A further resolution concerning certification of the general practitioner was also forwarded to the Royal College of Physicians and Surgeons of Canada.

Report of Committee on Maternal Welfare

This report stressed the fact that increased consultant facilities now exist, and should be more widely utilized. Attention was drawn to the need for adequate training facilities to fit students for general practice and graduates for certification. The latter portion of the report was referred to the Committee on Education.

Committee on Public Health

This report indicated that no major problems had been discussed during the year. Members of the Committee are, in many cases, members of the provincial health survey committees, and wish to await the reports before recommendations are made to Council. One can hardly escape the observation that the experience of this Committee will be duplicated in other aspects of the health survey, and that the well-known "Too little and too late" may again be the experience of the profession.

Report of the Committee on Approval of Hospitals for Interneship

Activities of the Committee for the year included the survey of certain hospital applications for approval, acceptance of an amendment raising the required autopsy rate from 15 to 20%, to parallel action of the Council on Medical Education and Hospitals of the American Medical Association. The Canadian Interne Placement Service which operates in conjunction with C.A.M.S.I. was reviewed. A resolution from the C.M.A. Executive Committee that a study of Hospital Standardization and Approval be made was approved by Council, and referred back to the Executive Committee to name personnel.

Report of Committee on Credentials and Ethics

A problem referred by a member two years ago having to do with selling (to members of the profession) shares in a wholesale drug house, part profits of which would go towards medical research was reviewed, but no alteration was made in the decision that such was not in accordance with the best ethical practices.

Report of Nominating Committee

Past Pres.	Dr. J. F. C. Anderson, Saskatoon
President	Dr. Norman H. Gosse, Halifax
President-Elect	Dr. H. B. Church, Aylmer, Que.
Chairman of Council	Dr. J. H. McPhedran, Toronto
Honorary Treas.	Dr. E. S. Mills, Montreal
General Sec.	Dr. T. C. Routley, Toronto
Assistant Sec.	Dr. A. D. Kelly, Toronto

Entertainment of General Council

It was not a case of "all work and no play" for those who attended the sessions of General Council. On Monday evening the Halifax members of the medical fraternity were hosts at a reception in the Bedford Room, Nova Scotian Hotel, with Dr. and Mrs. A. R. Morton receiving the guests. Dr. Morton had flown back to Halifax from Toronto, where he had attended sessions of the Canadian Public Health Association, to act as host. Chairman "Pat" Grant later provided a sumptuous repast in the Lord Nelson Hotel for members of the "Royal Order of Paper-Fasteners" on the occasion of the Annual (Informal) Dinner and Conference which the Canadian Medical Association sponsors for the medical secretaries. On Tuesday evening, after the arduous tasks of Council were completed, the New Brunswick Division was host at a reception in the Bedford Room, Nova Scotian Hotel, while, later, the Nova Scotia Division provided dinner and grand entertainment in the ballroom of the headquarters hotel. Dr. J. C. Wickwire, Liverpool, was a member of the quartet which presented sea chanties in very acceptable manner.

Scientific Program

The Central Programme Committee, under the Chairmanship of Dr. H. K. Detweiler, provided a stimulating programme designed to interest all members of the profession. In this day of special interests such a task is difficult, but the Committee is to be congratulated for the measure of success attained.

Annual General Meeting

This event becomes more colorful and assumes more the atmosphere of the university convocation. The meeting was carried through with despatch, and it was with a well-understood sense of relief that Dr. J. F. C. Anderson passed the badge of office to his successor, Dr. Norman H. Gosse. Later, Dr. and Mrs. Gosse received the felicitations of many friends at a reception which was followed by dancing. The buffet luncheon which followed the reception was said by more than one man to have "exceeded anything my wildest fancy could have imagined—those who like lobster or other sea food witnessed a display that would be hard to equal anywhere!"

Unlike the Wednesday weather which included rain in varying amounts, especially during the afternoon when a trip and tea on board H.M.C.S. Magnificent, was listed; Thursday was delightfully pleasant for the party which was held in the Public Gardens. Premier Angus McDonald and his wife welcomed each guest and were most gracious. Band music and good refreshments added to the natural beauty of the setting, and the various art awards were presented to winners.

Commercial Exhibits

No meeting of the federal or provincial association is quite complete without the representatives of many commercial firms. The number of exhibits was probably smaller than usual through lack of necessary space, but many friends were there—it was the twenty-seventh consecutive year for one representative!

Additional Meetings

Several national medical bodies and other groups held meetings prior to, coinciding with, or following that of the C.M.A. Days (and nights) were so filled with a number of things that a leisurely Eastward trip in preparation, and a similar return trip for recuperation were indicated. Altogether it was a very satisfactory experience!

To See Ourselves As Others See Us

Recently an advertisement for a physician appeared in the "Help Wanted—Male" column of the Toronto Globe and Mail. The request was listed amongst salesmen, commercial travellers, cashier clerks, construction inspectors, and cooks, etc., while under the heading "Skilled Help Wanted" appeared advertisements for mechanics, plumbers, Ford parts man, shinglers and welders. In this day, when we are public relation conscious, one wonders whether the classification was arranged by the clerk on the newspaper desk, or more likely, by the lack of attention on the part of the medical men on whose behalf the ad was inserted.

Driving Courtesy

Information concerning apparent lack of common driving courtesy was cited by the wife of a prominent member of our profession:

"One evening recently I had occasion to visit a patient in the General Hospital. On the way home I was offered a lift by a prominent Winnipeg lawyer. On two occasions between the hospital and the River Heights destination a car shot past, cut in front and forced us to bring the car to a standstill. In each case the lawyer remarked: 'And that's a doctor's licence!' "

Safe driving requires the co-operation of everyone, including medical men, the mere fact of an emergency call should re-emphasize the need for adequate driving care and the emergency is usually never sufficiently severe to involve reckless driving and danger to the lives of others.

The Health Survey

To all members of the Association who have co-operated so readily by completing the questionnaire which was sent out over the signature of the President of the Association and the Director of the Survey—a great big "Thank You" is in order. If any have been absent from the Province for work or play, if the first form or the followup were not received, additional copies may still be secured by calling 37 131, asking for "Health Survey Committee" and requesting the forms be sent —having done that, and received the forms, they should be completed and returned at once to the Association office!

Minutes of Meeting of Central District Medical Society

A meeting of the Central District Medical Society was held at the School for Mental Defectives, Portage la Prairie, at 8 o'clock on the evening of Tuesday, April 25th, 1950.

In the absence, through illness, of Dr. H. S. Atkinson, host for the evening was Dr. K. Anstreicher, Those present included Dr. C. M. Thomas (chairman), Doctors K. Anstreicher, G. P. Armstrong, G. M. Black, G. C. Fairfield, G. H. Hamlin, I. Jarema, J. W. Kettlewell, and J. C. Rennie, of Portage la Prairie, and Doctors Cecil Harris, A. T. Mathers, and M. T. Macfarland, of Winnipeg.

(1) Dr. Cecil Harris, Executive Director, Red Cross Blood Transfusion Service, addressed the meeting, including members of the Board of the Portage General Hospital, on the function, organization, and operation of a Blood Transfusion Service.

(2) Dr. A. T. Mathers presented several clinical cases, demonstrating unusual neurological conditions, and concluding with a discussion of Epilepsy.

(3) The Executive Secretary discussed various phases of the Association activity, including legislation introduced at the recent session of the provincial legislature, and the Health Survey which will be undertaken during the summer months.

Congratulations were extended to Dr. G. P. Armstrong, who was recently given a Life Membership in the College of Physicians and Surgeons, and chosen by acclamation to represent his constituency on the Council of that body.

Refreshments were served under the supervision of the school staff.

Northern District Medical Society

A meeting of the Northern District Medical Society was held at Dauphin on the evening of Tuesday, June 6th, 1950.

Present were: Doctors R. E. Dicks (Chairman) R. M. Creighton, A. S. Little, M. Potoski (Secretary), and W. G. Ritchie, of Dauphin; W. Bashucky, Winnipegosis; R. Fryer, Ethelbert; T. E. Kinash, Gilbert Plains; R. L. Gendreau, Ste. Rose du Lac; J. D. Adamson, M. R. Elliott, L. P. Lansdown, M. T. Macfarland, I. Pearlman, S. S. Peikoff, Winnipeg.

Following a substantial turkey dinner, served under the direction of the Lady Superintendent, Miss A. Pearson, her assistant, Miss Sinclair, and Dietitian, Miss McKinnon, the business and clinical sessions were held in the Auditorium of the Dauphin Health Unit.

Doctors I. Pearlman and S. S. Peikoff presented papers on the medical and surgical aspects of Biliary Disease. Doctors J. M. Lederman and Cecil Harris were unavoidably absent due to circumstances beyond the control of each.

Dr. J. D. Adamson who, as Chairman of a special committee of the Advisory Commission under the Health Services Act, was present with other members of the Committee. (Judge J. R. George, Commission Chairman, Mrs. A. Johnson and Mr. D'Eschambault) was prevailed upon by the Chairman to present a paper on "Poliomyelitis".

Good discussion followed each paper, and the Executive Secretary of the Association gave an outline of some matters recently dealt with by the Executive Committee, and invited co-operation of the profession in connection with the forthcoming questionnaire in connection with the Health Survey of the Province.

An enjoyable social time followed at the home of Dr. M. Potoski.

North-West District Medical Society

A meeting of the North-West District Medical Society was held at the Sacred Heart Hospital, Russell, Man., on the afternoon of Wednesday, June 7th, 1950.

Present were: Doctors D. Braunstein (Chairman), Binscarth; J. E. Hudson (Sec.-Treas.), of Hamiota; S. Bardal, Shoal Lake; J. G. L. Johnson, Rossburn; W. A. Large, Roblin; C. D. Lees, Oak River; T. I. Brownlee and T. W. Shaw, Russell; W. Sharman, Belmont; T. A. Lebbetter, M. T. Macfarland, J. R. Martin, D. L. Scott and C. B. Stewart, Winnipeg.

Following a brief business session at which Dr. J. E. Hudson was named representative of the district to the Nominating Committee, M.M.A., the scientific program was presented. Dr. C. B. Stewart discussed "The Treatment of Common Genito-Urinary Conditions", while Dr. T. A. Lebbetter gave a paper of "Coronary Artery Disease". Each paper was followed by numerous questions and the discussion period was valuable.

Dr. J. R. Martin outlined the aims, objects and achievements of the General Practitioners' Association, while Dr. D. L. Scott, President and Dr. M. T. Macfarland, Executive Secretary, brought greetings of the Association, and discussed such matters as Manitoba Medical Service, Diagnostic Cancer Clinics, Recent Legislation, Health Survey, Fixed Meeting dates, etc.

Following a social hour at the home of Dr. and Mrs. Shaw, a chicken dinner was served at Wyldwood, followed by an impromptu program of song, etc. The Winnipeg visitors set out upon what turned out to be an all-night affair through heavy rain.

Meeting
Brandon and District Medical Association

Wednesday, September 13th

Afternoon

3.00 Golf, Country Club, Brandon.
6.30 Recetpion, Prince Edward Hotel, Brandon.
7.00 Dinner, Prince Edward Hotel, Brandon.
8.30 Business and Scientific Meeting, Prince Edward Hotel.
Entertainment for the Ladies.

Suggested topics and speakers as follows:

"Obstetrical Difficulties."
Dr. A. W. Andison, Winnipeg.

"Breast Carcinoma."
Dr. R. W. MacCharles, Winnipeg.

A cordial invitation is extended to all doctors to attend.

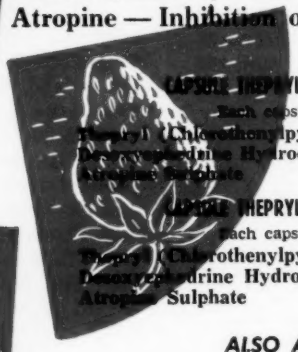
TRIPLE ANTIHISTAMINE

thepryl

COMPOUND

for the histamine basis of allergy

1. Thepryl — Chemical competition
2. Desoxyephedrine — Stimulation of the sympathetic
3. Atropine — Inhibition of the parasympathetic



CAPSULE THEPRYL COMPOUND 25 mg.

Each capsule contains;

Thepryl (Chlorothenylpyramine Citrate)		25 mg.
Desoxyephedrine Hydrochloride		0.625 mg.
Atropine Sulphate	(1/2000 gr.)	0.032 mg.

CAPSULE THEPRYL COMPOUND 50 mg.

Each capsule contains;

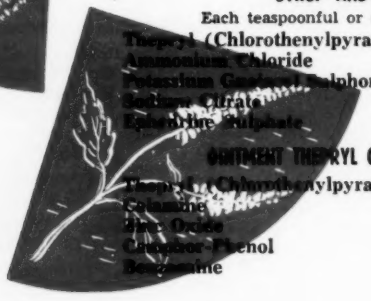
Thepryl (Chlorothenylpyramine Citrate)		50 mg.
Desoxyephedrine Hydrochloride		1.25 mg.
Atropine Sulphate	(1/1000 gr.)	0.064 mg.

ALSO AVAILABLE

THEPRYL EXPECTORANT SYRUP AND CAPSULE

Each teaspoonful or capsule contains;

Thepryl (Chlorothenylpyramine Citrate)	15 mg.
Ammonium Chloride	2 grs.
Potassium Guaiacol Sulphonate	1 gr.
Sodium Citrate	1 gr.
Ephedrine Sulphate	1/16 gr.



OINTMENT THEPRYL COMPOUND

Thepryl (Chlorothenylpyramine Citrate)	2%
Calamine	10%
Zinc Oxide	5%
Camphor-Phenol	1%
Benzocaine	1%

Thepryl Reg'd Trade Mark for Chlorothenylpyramine Citrate

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LONDON - CANADA

ETHICAL PHARMACEUTICALS

Winnipeg Medical Society—Notice Board

K. R. Trueman, *Vice-President*
B. Dyma, *Trustee*
T. E. Holland, *President*
William J. Boyd, *Treasurer*
Sam. A. Boyd, *Secretary*

Committee Reports

Secretary

To the President and Members of
The Winnipeg Medical Society:

The Winnipeg Medical Society has had a busy and constructive year. Eight regular meetings and four special meetings were held during the term and the high quality and variety of interest of the subjects presented stimulated a large attendance at each.

The Gordon Bell Memorial Lecture was revived under the auspices of the Benevolent Fund of the Society and by this means the general public was privileged by an address from Sir Lionel Whitby. The Society was further honored by addresses from the following distinguished visitors: Sir John Parkinson, Sir Heneage Ogilvie, Professor F. H. Bentley, and Sir Reginald Watson-Jones, all from Great Britain; Dr. R. D. Dripps and Dr. A. W. Adson from the United States; Dr. Alton Goldbloom of Montreal, and Dr. T. L. Fisher from Ottawa. Following the principle established last year, one of the regular meetings took the form of a series of demonstrations of the clinical and laboratory work in progress in a hospital. This year this meeting was held in the Outpatient Department of St. Boniface Hospital, and the excellence of organization and quality of the presentation reflects great credit on the members of the Staff of that Hospital.

The routine business of the Society was carried on through regular meetings of the Executive Council of the Society under the efficient chairmanship of your President, Dr. T. E. Holland.

Respectfully submitted.

S. A. Boyd.
Secretary.

Treasurer

To the President and Members of
The Winnipeg Medical Society:

Herewith certified financial statement from our auditors, Messrs. Thornton, Milne & Campbell.

All of which is respectfully submitted.

W. J. Boyd,
Treasurer.

To the President and Members,
The Winnipeg Medical Society,
Winnipeg, Manitoba.

Dear Sirs:

We have audited the accounts of the Society for the period ended 30th April, 1950 and submit herewith the following relative financial statements:

EXHIBITS:

"A" Balance Sheet as at 30th April, 1950.
"B" Statement of Revenue and Expenditure for the period ended 30th April, 1950.

The operations for the period, as set forth in Exhibit "B," have resulted in an excess of receipts over disbursements of $1,849.50. Membership fees received are in accordance with duplicate receipts examined by us but are not subject to further verification. Expenditures have been sufficiently authorized and vouched.

In accordance with the Minutes of 21st November, 1949, and subject to the Minutes of 15th May, 1946, the sum of $750.00 has been placed in the Special Library Fund for the use of the Library Committee of the Faculty of Medicine. A statement of the transactions affecting this account during the year is also shown in Exhibit "B."

We obtained from the Bank of Toronto verification of the bank balances, subject to allowances for outstanding cheques as shown by the books.

During the period, the Society disposed of $1,000.00 Dominion of Canada 3% 1952 bonds at a profit of $12.50 as reflected in the Surplus Account. In addition, $3,000.00 Dominion of Canada 3% 1966 bonds were purchased at a cost of $3,066.25. All changes have been duly authorized.

At present, the Society's investments comprise the following issues of Dominion of Canada bonds:

Par Value		Cost	Market Value
$1.000.00	Dominion of Canada 3% 1957,	$1,000 00	$1,022.50
3,000.00	Dominion of Canada 3% 1966,	3,066.25	3,067.50
$4,000.00		$4,066.25	$4,090.00

These securities are lodged with the Bank of Toronto for safekeeping and are in accord with confirmation received from the Bank. All interest, on a received basis, has been duly accounted for on the books of the Society.

In accordance with our recommendation, the accumulated cost of office furniture and equipment as at 15th May, 1949, has been written off to Surplus Account. The cost of additions during the current period has been charged directly to operations as reflected in Exhibit "B." For your further information, the approximate value of equipment on hand as at 30th April, 1950, amounted to $245 95.

To the best of our knowledge and belief, all liabilities applicable to the period under review have been recorded on the books.

In conclusion, we wish to express our appreciation of the courtesies extended to us during the course of our work.

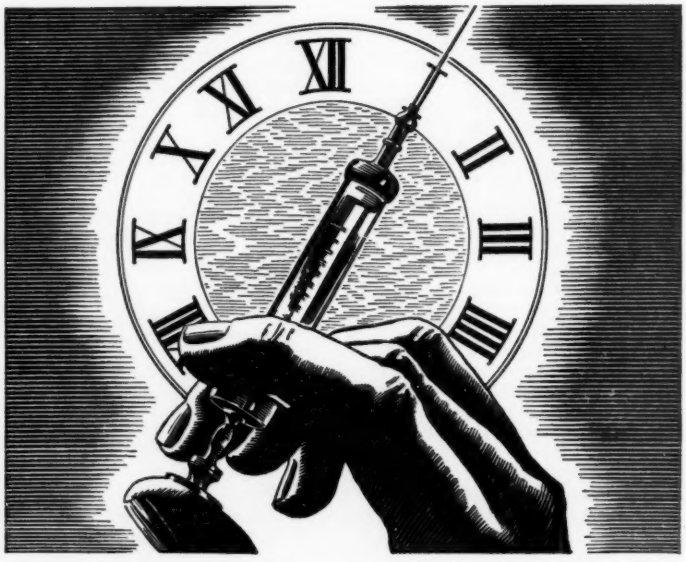
Yours very truly,

THORNTON, MILNE & CAMPBELL,
Chartered Accountants.

Hyperduric

INJECTION SOLUTIONS

for P-R-O-L-O-N-G-E-D action



Time E-X-T-E-N-D-E-D

A boon to Patient, Doctor and Nurse

This series is the result of a search for effective methods of prolonging the pharmacological effect of morphine and other bases. Clinical trials have demonstrated that for a given dose of morphine the period of narcosis can be considerably extended if the base is administered in the form of mucate instead of the usual salts such as tartrate or sulphate. This prolongation of effect is also obtained with the mucic acid compounds of other active bases such as epinephrine, hyoscine and atropine.

The following Hyperduric Injection Solutions are now available – in boxes of 12 ampoules of 1.1 c.c.

Hyperduric Atropine gr. 1/100 per c.c.
Hyperduric Epinephrine 1 in 1000 solution.
Hyperduric M.H.E.
morphine gr. ¼ per c.c.
hyoscine gr. 1/80 per c.c.
epinephrine gr. 1/160 per c.c.

Hyperduric Hyoscine gr. 1/100 per c.c.
Hyperduric Morphine gr. ½ per c.c.
Hyperduric Diamorphine gr. ⅛ per c.c.
Hyperduric Morphine & Atropine.
morphine gr. ¼ per c.c.
atropine gr. 1/75 per c.c.

Complete literature supplied on request.

M-57

THE ALLEN AND HANBURYS COMPANY LIMITED • TORONTO, ONT. • LONDON, ENG.

Exhibit "A"

Balance Sheet
As at 30th April, 1950

ASSETS

Cash:			
On deposit with Bank of Toronto			$1,905.14
Investments—at Cost:		Par Value	
Dominion of Canada Bonds,			
3% 1957		$1,000.00	$1,000.00
3% 1966		3,000.00	3,066.25
			4,066.25
			$5,971.39
Special Library Fund:			
Cash:			
On deposit with Bank of Toronto			978.36
			$6,949.75

LIABILITIES

Membership Fees Paid in Advance			$ 20.00
Surplus:			
Balance as at 15th May, 1949		$5,106.43	
Add:			
General Funds — Excess of Receipts over Disbursements	$1,849.50		
Gain on Sale of Bonds	12.50		
		1,862.00	
		$6,968.43	
Less:			
Appropriated for Library Fund	750.00		
Office Furniture and Equipment written off	267.04		
		1,017.04	
			5,951.39
			$5,971.39
Special Library Fund Reserve:			
Surplus:			
Unexpended Balance, 15th May, 1949		$ 706.76	
Add:			
Excess of Receipts over Disbursements		271.60	
			978.36
			$6,949.75

Exhibit "B"

Statement of Revenue and Expenditure
For the period ended 30th April, 1950
General Funds

RECEIPTS

Annual Dues:		
Current Year—Active Members	$3,590.00	
Associate Members	16.00	
Prior Years	210.00	
		$3,816.00
Bond Interest		52.89
		$3,868.89

DISBURSEMENTS

Audit Fees	$ 25.00
Catering	123.20
Donations	12.00
General Expense	106.35
Gordon Bell Memorial Lecture	398.06
Lantern Expense	65.00
Office Equipment	53.00
Printing, Stationery and Postage	214.28
Salaries	862.50
Special Speakers	124.00
Telephone	36.00
	2,019.39
Excess of Receipts over Disbursements	$1,849.50

Library Fund

RECEIPTS

Appropriated from General Surplus	$ 750.00	
Bank Interest	11.37	
		$ 761.37

DISBURSEMENTS

Books purchased	$ 325.77	
Library supervision	164.00	
		489.77
Excess of Receipts over Disbursements		$ 271.60

Benevolent Fund

9th May, 1950.

To the Members,
The Winnipeg Medical Society Benevolent Fund,
Winnipeg, Manitoba.

Dear Sirs:

In accordance with your request, we have made an audit of the transactions affecting The Winnipeg Medical Society Benevolent Fund for the period ending 30th April, 1950, and submit herewith our statement pertaining thereto:

Balance, 15th May, 1949		$2,001.00
Add: Receipts		85.00
		$2,086.00
Less: Disbursements		50.00
Balance on deposit in The Bank of Toronto		$2,036.00

Donations received are in accordance with duplicate receipts examined by us. We are informed that all disbursements made from the Fund will be duly authorized at the next committee meeting.

Yours very truly,
THORNTON, MILNE & CAMPBELL,
Chartered Accountants.

Report of Trustees

To the President and Members of
The Winnipeg Medical Society:

As Senior Trustee, I wish to report the following securities as being held in Safety Deposit Box, Bank of Toronto, 394 Portage Avenue:

Dominion of Canada Bond, 3%, due 1st May, 1957	$1,000.00
Dominion of Canada Bond, 3%, due 1st September, 1966	3,000.00
Balance on Deposit, Bank of Toronto, 29th April, 1950	1,905.14

The aforesaid bonds and bank deposit have been vouched for in the Auditor's report.

I have personally inspected the office equipment of the Society at 604 Medical Arts Building, the equipment in the Manitoba Medical College in the custody of the Caretaker, and Lantern in care of Mr. Gordon Axtell, and found them to be as listed herein:

Office Equipment at 604 Medical Arts Building:

1 Steel Filing Cabinet, 3 drawers; 1/2 Interest in Elliott Addressing Machine; 1/3 Interest in Mimeograph Machine; 1/3 Interest in Underwood Typewriter, 14" Carriage, Serial No. 5732553-14; 1/3 Interest in "Copyright" Holder; 1/3 Interest in Burroughs Adding Machine.

Equipment in Manitoba Medical College in custody of Caretaker:

12 Wooden Chairs; 4 Wooden Trestles and 2 Wooden Table Tops for same; 32 Cups and Saucers; 1 Coffee Urn; 1 Gavel, made from wood from the ruins of the Royal College of Surgeons and presented to the Winnipeg Medical Society by Dr. John C. Hossack; 1 Plaque, Honour Roll of Past Presidents (in Physiology Lecture Room of the Medical College), book value $218.64.

In Care of Mr. Gordon Axtell:

1 Delinescope Lantern, Model OJR, No. 3647, made by Spencer Wells Co. of Buffalo, New York, and one spare bulb for same.

Marjorie R. Bennett,
Senior Trustee.

Membership Committee

To the President and Members of
The Winnipeg Medical Society:

The present total membership is 452, made up as follows:

Active Paid-up Members	361	
Associate Paid-up Members	8	
	—	369
Life Members	18	
Non-Active Members	11	
New Member (Comp. to end of season)	1	
Internes (Complimentary)	4	
Sick Member (not billed for fees)	1	
Membership Fees Unpaid	48	
	—	73
		452

22 members have been lost to the Society during the year, 4 being deceased and 18 having left the city; 5 of this number had paid dues for the current year, so that the actual loss in dues was only 17 in number.

15 names have been added to the Society's membership roll, 12 being new members and 3 former members having been reinstated.

This, therefore, makes a decrease in the total members from 1948-1949 of 2, which was 454 as against 452 for the current season.

A total of 558 doctors reside in the City of Winnipeg; 80 of whom are not members of the Society, as follows:

Temporarily licensed 1 year with C. P. & S.	10
Retired	19
Practising	77

Respectfully submitted.

A. E. Childe,
Chairman.

Standing Legislative Committee of Fifteen

To the President and Members of
The Winnipeg Medical Society:

Only one meeting of this committee was held during the past year. This was called on rather short notice on the evening of April 20th, 1950.

The Legislature had been in session, but until that time no legislation was considered which particularly affected the Medical Profession. We were receiving, through the office of the Minister of Labor, copies of proposed legislation. There had been a rumor received on the 14th April, recommending some proposed amendments to the Workmen's Compensation Act, but no definite information could be obtained.

On the afternoon of April 20th, word was received through the Chief Medical Officer, Workmen's Compensation Board, that the Act amending the Compensation Board Act had that day received first reading, and would probably receive second reading at the evening session. It was still not possible to receive information concerning this through the Minister. The Local "Press" indicated that the changes were designed to include Osteopaths and Chiropractors in the Act.

The Committee was therefore called to discuss what action, if any, the Medical Profession could take. Though the Bill had received first reading and was held for second reading, it was not yet printed, and therefore was not available for study. It was felt at the meeting that, since the Bill was a Government Bill, introduced by the Minister of Labor, any attempt on the part of the Medical Profession to block or delay the Act would be futile.

It was decided that a letter should be written to the Premier and Members of Cabinet, with copies to Opposition Members, outlining the fact that the majority of injuries sustained by workmen do not come within the training of either the Chiropractor or Osteopath. The Act licensing these practitioners restricted the Osteopath to the field of Minor Surgery, while the Chiropractor is allowed to do no surgery whatever. It was further recommended in the letter, that in the interests of the workmen, the first visit should be made to a Medical Practitioner, following which treatment from the Osteopath or Chiropractor could be arranged, with the approval of the Chief Medical Officer, Workmen's Compensation Board .

Dr. Macfarland was also authorized to meet Mr. T. W. Laidlaw, Solicitor. It was felt that representation at the "Law Amendments Committee" would be equally futile. The Act received third and final reading April 22nd. No other legislation affecting the Medical Profession occurred during this session.

All of which is respectfully submitted.

Ross H. Cooper,
Chairman.

Library Committee

To the President and Members of
The Winnipeg Medical Society:

The Medical Library of the Medical College has had its busiest year on record. The number of books and journals borrowed was 13,039, an increase of 2,169 or 20% over the record year of 1946-47. Of the 530 physicians registered in the city, 257, or nearly one-half, borrowed books or journals from the library. The proportion of library users among city doctors apparently remains fairly constant from year to year. However, the users during the past year made much greater use of the library. The loans to Winnipeg physicians comprised 1,659 books and 3,554 journals and serials. an increase of 1,635 items, or 45.7%, over the last session. What this increasing literary activity among one half of our members will lead to, eventually, will be interesting to watch.

The purchasing fund provided by the Winnipeg Medical Society was used to obtain 63 books and 2 serials, and to send 9 volumes for binding. In late April, 92 volumes have been prepared and sent to the binder. This will appear in next year's report, but the cost of this item is covered in part by a special allocation made by this Society in November, 1947.

Last year your representative to the Library Committee, Doctor Ross Mitchell, recommended an increase of the Society's annual grant from $500.00 to $750.00. He pointed out that this was less than $2.00 yearly per member, and less than one third the cost of a new book. This increase has been approved by Council and I can assure you that it was welcomed by the Library Committee.

Evening library hours were arranged for another trial period of four months, January to April, inclusive. In the first three months, the average monthly attendance was 52 visits, made by 85 readers, while in April there were only 30 visits. This represents an average attendance of 2.28 readers per evening, and with a salary charge of $164.00 this service cost about $0.85 per visit. However, as compared with the 1949 trial, twice as many non-key holders made three times as many visits in 1950. It is the belief of some that if the library were open in the evenings from October to April the patronage would

increase on the part of both students and graduate readers. It might even affect that mass of 52% of Winnipeg doctors who either read only their own books and journals or do not read at all!

The main library problem, of course, is that of space accommodation. The crowding in the reading rooms and in the stacks is almost intolerable. It discourages a normal use of the library and it militates against efficiency of operation. This matter is of great concern to the University and one hears interesting rumours of projected construction to provide entirely new library accommodation. Under present circumstances, the profession of this province should be all the more grateful to Miss Monk and her staff who make every effort to assist busy practitioners in securing literature and information of the most diverse kind.

Respectfully submitted.

J. Wendell Macleod,
Representative to Library Committee,
Faculty of Medicine,
University of Manitoba.

Programme Committee

To the President and Members of
The Winnipeg Medical Society:

I beg to submit the report of the programme committee for the season 1949-1950.

The details of the programme are matters of record. We were fortunate in having as guest speakers several notable men of medicine. Their presentations were extremely interesting and all were well attended. In order to make time available for these speakers, programmes, which had been planned for several weeks or months previously, had to be changed. This committee wishes to express its thanks to Dr. Thorlakson and Dr. Paul Green, who were to have presented papers at the December, 1949 meeting, which was given over to Sir Heneage Ogilvie instead.

Dr. R. O. Burrell gave valuable assistance as the other member of this committee of two, and was mainly responsible for the success of the St. Boniface Hospital meeting .

The problem of preparing good programmes well in advance and then making last minute changes in order to take advantage of the visit of outstanding phvsicians is one for the next year's committee to consider. I feel that the regular meetings of the Winnipeg Medical Society should be used as a forum for local speakers except, perhaps, that meeting which coincides with the annual Post Graduate course. Visiting speakers should be paid the compliments of a special meeting, well publicized and preceded by a subscription dinner. This would not only furnish a more suitable setting for such a speaker but the expense incidental to bringing such a speaker here would be defrayed.

The committee feels that at least one meeting be devoted to medico-social problems, such as cancer control, Manitoba Medical Service and government clinics.

Respectfully submitted.

Harry Medovy.
Chairman.

Representative to Council of Social Agencies

To the President and Members of
The Winnipeg Medical Society:

March 20th, 1950 — Luncheon meeting at the Y.W.C.A. — re proposal of Manitoba Optometric Society to organize a Welfare Clinic, in the Red Cross Building, for the care of indigent patients requiring refraction, etc.

Following detailed reports from the O.P.D. Children's, St. Boniface, and General Hospitals, Institute of the Blind, Old Age Pensions, and Mothers' Allowance Dept., it was decided that care in this field is adequately provided for, and the Council of Social Agencies could not possibly assume responsibility for the requested expense of suporting a receptionist, clerical staff, etc.

Mrs. McQueen was requested to thank the Optometrists for their generous offer, and suggest that indigent patients passing through their hands be referred to one of the already organized clinics.

April 26th, 1950—Legislative Buildings—A general meeting was called, which, unfortunately, I was unable to attend. Mrs. McQueen reports to me that the only business arising was the Amendment of the Constitution of the Social Agencies to bring it into line with the Constitution of the Community Chest.

The Annual Meeting of the Agencies, postponed because of flood conditions, will be held June 20th. It should be very interesting as the Council and Central Volunteer Bureau were most active during the flood emergency.

Respectfully submitted.

K. Borthwick-Leslie,
Representative.

Representative to Executive Committee, Manitoba Medical Association

To the President and Members of
The Winnipeg Medical Society:

The Manitoba Medical Association Executive Committee held meetings in the Medical Arts Club Rooms once monthly in November, December, January, February, March, April and May.

All meetings except that in May were held on Sunday afternoon, and their duration ranged from three hours to four hours and fifteen minutes. Coffee and cake in mid-session provided the necessary stimulus to complete each program.

A great number of questions of importance to the medical profession of Canada, of Manitoba, and of the City of Winnipeg were included in the agenda. Only those of special interest to Winnipeg members will be briefly outlined in this report:

(1) Diagnostic Facilities:

The report of the canvass of the medical profession as to the necessity for these facilities was forwarded to the Minister of Health and the City daily papers.

(2) Manitoba Medical Service:

The ways and means of introducing this plan to other areas of the Province has taken up considerable time in most of the meetings. A new organization named "Blue Shield" was deemed to be in direct opposition to M.M.S. and rural physicans have been advised against joining this insurance plan. M.M.S. has had difficulty in securing a sufficient percentage of rural inhabitants to make the plan economically sound. There is a plan now in operation to enlist individual contracts in the country.

(3) Retirement Fund for Doctors:

A committee of the Canadian Medical Association is working on deductions of payment to retirement fund of doctors and will report later.

(4) Spotlights:

Representation was made to the Manitoba Government to have the Highway Act amended to permit active practitioners the use of spotlights on their cars. This was turned down.

(5) Osteopaths and Chiropractors:

The M.M.A. Executive Committee was informed at too late an hour to prepare a brief against legislation by the Provincial Government to permit osteopaths and chiropractors to legally treat workmen under the Workmen's Compensation Act.

However, a letter was sent to the appropriate government officials, deploring the fact that the M.M.A. had not been sufficiently forewarned and intimating that the passage of this bill was not in the best interests of the workmen concerned.

(6) Cancer Clinics:

Plans are in progress to attempt to draw up a scheme for diagnosis and treatment of Cancer patients which will be acceptable to the Governments, the laity, and the medical profession.

Respectfully submitted.

M. M. Brown,
Representative.

Winnipeg Community Chest Campaign Committee

To the President and Members of
The Winnipeg Medical Society:

In accordance with an arrangement made between the Executive of this Society and the Winnipeg Community Chest, a canvass of the doctors was carried out in Greater Winnipeg by the doctors themselves, as a part of the Community Chest 1949 Campaign.

It was hoped by this change in approach to obtain a greater donation from the doctors generally.

The campaign was successful in that our quota was exceeded, but it was felt that the donations generally did not come up to our expectations.

The quota set for the doctors in 1949 (which was 10% above the 1948 figure) was $8,678.00. The actual sum collected was $9,822.50. The average donation (554 doctors) was $17.73.

Dr. Arthur Childe was joint chairman with me in this campaign, the success of which was only made possible by the numerous doctors who conducted a group canvass in their own locality. The efforts of these captains is very much appreciated.

Respectfully submitted.

F. Hartley Smith,
Chairman.

Section of Anaesthesiology

To the President and Members of
The Winnipeg Medical Society:

Eight official meetings were held during the past year.

The Section, which comprises the Winnipeg Anaesthetists' Society and the Manitoba Division of the Canadian Anaesthetists' Society was host to the Western Divisions of the Canadian Anaesthetists' Society at meetings held on March 23, 24 and 25, 1950. Dr. Leroy Van Dam of the University of Pennsylvania, and Dr. R. A. Gordon, Secretary of the Canadian Anaesthetists' Society, were guest speakers.

The Section now has twenty members, an increase of two over the previous year.

The new Executive elected for the year 1950-51, are:
Chairman—Dr. Marjorie R. Bennett.
Secretary-Treasurer—Dr. Bernadine Roe.

Respectfully submitted.

R. G. D. Whitehead,
Secretary.

Eye, Ear, Nose and Throat Section

To the President and Members of
The Winnipeg Medical Society:

Two meetings of this Section have been held during the past year.

At the first meeting Dr. E. J. Washington presented four cases of Frontal Sinusitis with complicating Osteomyelitis. Dr. Robt. Black presented a case of Epidermoid Carcinoma of the middle ear, and Dr. J. E. Rose presented a case of Toxic Amblyopia due to tobacco.

At the second meeting the Section voted for affiliation with the Manitoba Medical Association. This was applied for and has been granted. A film was shown giving the technique for the use of the Stone Jardin Mobile Implant.

The March meeting was cancelled as a combined meeting of the Alberta, Saskatchewan and Manitoba Eye, Ear, Nose and Throat Societies was held in Saskatoon in the latter part of March.

The final meeting this year will be held in the latter part of May.

Respectfully submitted.

J. E. Rose,
Secretary.

Section of Internal Medicine

To the President and Members of
The Winnipeg Medical Society:

The past year has been an active and interesting one for this Section.

Scientific papers have been presented by Doctors C. H. A. Walton, J. M. Kilgour, J. P. Gemmell, William Perry, Ben Lyons and R. E. Beamish.

In addition to this, there have been social evenings with informal discussions by Sir John Parkinson of London, England, and Doctors Duncan and Walter Graham, of Toronto.

The Internists' Section also played some part in the organization of the Sectional Meeting of the American College of Physicians which was held in February, 1950. Two subcommittees have been appointed: 1. Program Committee. 2. Economics and Public Relations Committee.

As Secretary of the Section, I would like to take this opportunity of thanking all members of the Section for their co-operation in the past year.

All of which is respectfully submitted.

A. B. Houston,
Secretary.

Obstetrics and Gynaecology Section

To the President and Members of
The Winnipeg Medical Society:

Four regular meetings were held during the winter under the Chairmanship of Dr. W. J. McCord.

Dr. Elinor Black addressed the Section, giving a resume of her trip to Europe and the Eastern United States. Dr. L. R. Coke addressed the Section on "Heart Disease and Pregnancy". Dr. Jessie McGeachy addressed the Section on "Psychosomatic Considerations of Gynaecological Problems". Dr. J. P. Gemmell addressed the Section on "The Role of the Thyroid Gland".

The Annual Meeting of the Section, at which election of officers take place, has been postponed until the early fall.

Respectfully submitted.

A. R. Tanner,
Secretary.

Radiological Section

To the President and Members of
The Winnipeg Medical Society:

Two meetings were held during the winter, with an average attendance of fifteen.

The agenda of the meetings consisted of:
1. Resumes of conventions attended by various members;
2. Discussions on economics related to the specialty;
3. Round table discussions on interesting films.

The retiring executive were re-elected for the forthcoming year.

The section lost one of its leaders in the death of Dr. J. C. McMillan.

Respectfully submitted.

A. W. McCulloch,
Secretary.

COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA

Discipline Committee

Winnipeg, Man.,
May 5th, 1950.

A meeting of the Discipline Committee was held in the Medical Arts Club Rooms at 12.30 p.m., on Friday, May 5th, 1950.

Present: Dr. Edward Johnson (chairman), Dr. C. E. Corrigan, Dr. H. Guyot, Dr. C. B. Stewart, Dr. I. Pearlman, vice-President, ex-officio, and Dr. M. T. Macfarland, Registrar.

The Committee reviewed the minutes of the Discipline Committee meeting held May 3, 1949, the minutes of the Council meeting held May 18, 1949, and report of the Discipline Committee to Council on October 19, 1949, together with correspondence from Mr. T. W. Laidlaw, College solicitor, and the Registrars of several provincial licencing boards.

Considerable discussion ensued.

Motion: "THAT this committee approves the introduction of measures for dealing with minor disciplinary infractions, and recommends that Council enact the necessary by-law in accordance with Sec. 25 of the Medical Act." Carried.

Motion: "THAT legal opinion regarding the proposed by-law be secured prior to the next meeting of Council." Carried.

It was further recommended that if, and when such by-law is passed by Council, notification be sent to the various hospitals, Workmen's Compensation Board, Manitoba Medical Service Department of Veterans' Affairs, etc.

Council Meeting

Winnipeg, Man.
May 23rd, 1950.

A special meeting of the Council of the College of Physicians and Surgeons of Manitoba, was held Tuesday, May 23rd, 1950, at 2.00 o'clock p.m., in the Medical College, Winnipeg.

The President, Dr. Edward Johnson, called the meeting to order.

The business before the meeting was as follows:

1. Roll Call

The following members were present: Doctors Edward Johnson, President; I. Pearlman, Vice-President; M. T. Macfarland, Registrar; T. H. Williams, Treasurer; Dr. G. P. Armstrong, Dr. B. D. Best, W. J. Boyd, C. S. Crawford, B. Dyma, J. S. Poole, F. K. Purdie, T. W. Shaw, C. B. Stewart, C. H. A. Walton, C. W. Wiebe.

A period of silence was observed in memory of the late Dr. A. A. Alford.

The President welcomed the new member of Council, Dr. G. P. Armstrong, representing the Constituency of Portage la Prairie, and congratulated him on his recent Life Membership with the College.

2. Reading of the Minutes and Their Approval

The President advised that mimeographed copies of the minutes of the Annual Meeting of Council held October 19, 1949, had been forwarded to each member of Council.

Motion: "THAT the minutes of the Annual Meeting of Council held October 19, 1949, be accepted as having been read." Carried.

Business Arising from Minutes of Council Meeting Held October 19, 1949

A. Revision of By-Laws.

Dr. T. H. Williams reported that he, Dr. C. B. Stewart, and Dr. M. T. Macfarland, had met, as requested by Council in May, 1949, to study and revise the By-Laws, Rules and Regulations. He stated that the order had been changed somewhat to correspond with the Medical Act, some minor changes had been made to clarify the original by-laws, and some additions made through the years were written in. A copy of the revised by-laws had been forwarded to each member of Council.

Notice of Motion by Dr. T. H. Williams:

"THAT the revised By-laws, Rules and Regulations be accepted as printed, with power to make any minor changes which may be suggested."

B. Appointment of Auditors

Dr. Williams explained that the appointment of auditors had been deferred from the October meeting of Council since it was the feeling that the figure for auditing the books had been increased too drastically. He said that the amount of business had increased in the last few years, therefore the amount of checking by the auditors had increased, and that the costs of everything had gone up. He stated that since the auditors knew the books, he wondered whether we could find a firm of auditors who would do the work for any less. Also the firm of Price Waterhouse and Company was a nationally known firm with a high reputation for stability.

Motion: "THAT Price Waterhouse & Company be auditors for the College of Physicians and Surgeons of Manitoba for the year 1949-1950." Carried.

3. Reports of Officers and Their Consideration

A. Treasurer's Report.

Dr. T. H. Williams presented the following report:

Investment Trust Account:

Your Treasurer begs to report a balance in this account of $57,000 in Dominion of Canada 3% long

Ortho presents *Massé* nipple cream,

DESIGNED SPECIFICALLY FOR ANTEPARTUM AND POSTPARTUM NIPPLE CARE

Massé is an antiseptic, readily absorbed, nipple cream containing 9-amino acridine 1:1000, and allantoin 2%. Massé is active against a wide variety of bacteria, stimulates healing of nipple abrasions and fissures, and has excellent emollient properties.

INDICATIONS: For prophylactic nipple care during the antepartum and nursing periods, and for the treatment of cracked nipples.

Advantages of Massé in prophylactic nipple care:

1. *Highly effective* against a wide variety of pathogenic bacteria.
2. Relatively *nontoxic* and *nonirritating*.
3. Actively *promotes healing*.
4. Has *definite debriding properties*.
5. *Readily absorbed*, obviating the use of waxed paper, etc., over nipples after application.
6. *Nonstaining*.
7. *Emollient effect* helps prevent nipple trauma.
8. *Need not be washed* off prior to nursing.
9. Has *pH of 5.6* approximating that of nipple epithelium.

ortho PHARMACEUTICAL CORPORATION (CANADA) LIMITED — TORONTO

Gynecic Pharmaceuticals

term bonds and a cash bank balance of $1,055.55.

There has been paid out from this account since our last meeting the sum of $750.00 annual grant to the Medical Library.

Gordon Bell Memorial Trust Account.

There are in the safety deposit vault a total of $25,000 in Dominion of Canada 3% long term bonds and the bash bank balance stands at $1,197.19. There have been no withdrawals from this account as no scholarship has been granted by the Committee. Funds from this account may only be used for research scholars and may not be lowered below $20,000. It is to be hoped a satisfactory applicant may be found worthy of assistance from this fund.

Current Account.

The balance in this account today stands at $2,404.92. This account came perilously near the zero mark at the end of last year when the bank balance at December 30th was only $74.78. Had it not been for the increase to $5.00 annual fee our month to month balance would not have had a safe margin. The present bank balance will not any more than see us safely through the lean months until January, 1951.

Your Treasurer begs to draw your attention to the disastrous flood which has caused heavy loss and in many cases financial ruin to citizens of our province in all walks of life. It has not spared the members of our profession throughout the flooded areas of the Red River Valley. A magnificent effort is being made throughout Canada and especially in our own province to re-establish homes laid waste and give back hope and some measure of comfort to the aged and infirm who have lost all. Your Treasurer has steadfastly resisted claims on our reserve funds and these have increased steadily since he came into office. Now, however, I wish to state that we would be well advised to sell some of our bonds and invest the proceeds in humanity in the persons of flood disaster victims. This is an investment in the future well being of our province and in the goodwill of our people. We ought not to lose sight of other objectives we have had for these reserve funds, but we must discharge our responsibility in this present great need.

Respectfully submitted,
T. H. Williams, M.D., C.M.,
Treasurer.

Motion: "THAT the Treasurer's report be adopted." Carried.

Manitoba Flood Relief Fund

A letter was presented from the Secretary, Medical Committee, Manitoba Flood Relief Fund, requesting a donation from the funds of the College of Physicians and Surgeons of Manitoba.

Dr. ..... stated that the question arose whether the College had the power to make a donation. He quoted Section 91 (2) of the Medical Act, and said there were sufficient numbers of members of the College who had suffered financial loss and in some cases complete ruin, that anything the College might do to reinstate them would be insufficient, and under this section we might act in making a donation to the Flood Relief Fund towards the awards which will undoubtedly be made to members of the profession to reinstate and rehabilitate them.

In connection with the amount of donation, he said there was an idea in the back of his mind that if the reserve funds of the College could be brought to a sufficient amount they might purchase in Winnipeg, in the area south and east of the Medical Arts Building, a well-constructed house to be the home of the C.P. & S., which could also be the headquarters of the M.M.A. and W.M.S. There might also be a number of rooms available for those coming in from the country to attend meetings who may have trouble locating accommodation elsewhere. While this would be a very nice thing to have, he considered there would be difficulty in answering the colleagues if something were not donated. He suggested a donation of $10,000, which would entail the sale of $9,000 in bonds and the rest in cash. Dr. Williams said he was against any segregation of the relief fund, but to comply with the word in the Medical Act, an amount could be sent earmarked for the rehabilitation of the medical profession. He said it had been done before.

Dr. ——— said that the policy of the College had been that we do not donate any of the reserve fund to charity organizations since each individual member contributes. He said it would be much easier for him as a member of Council to donate the money the College has in reserve, than it would be to donate on his own, but he was opposed to that idea. He thought the donation from the medical profession should be individually or by groups. He said there was no right under the Medical Act, and if we gave to the Flood Relief Fund it might be expected in subsequent fund appeals.

Dr. ..... said it was true that in the past the College had refrained from making a donation, but that this flood was a precedent never present before in the memory of the members present, and the donation is not altogether charity. He thought the money would be returned to the Province of Manitoba in a larger per cent than the 3% the bonds are now drawing. The donation is not something we should consider as a replacement for individual donations. Dr. Stewart said it was very fortunate that the College had money to help support the calamity which has overtaken the

province, and thought a donation should be made to the Flood Relief Fund.

Dr. ..... thought that everyone was agreed that a donation should be made, but questioned the legality of giving it to the general fund.

Dr. ..... thought that each member of the College should contribute individually as much as possible, and that the funds of the College be used for some purpose purely medical.

Dr. ..... said that this was an emergency, almost a catastrophe, which had never happened before, and there was no precedent. He thought that a donation should be given to the Fund.

Motion: "THAT the sum of Ten Thousand Dollars ($10,000.00) be donated from the Investment Trust Account to the Manitoba Flood Relief Fund, if our legal advisor agrees that this is within the provisions of the Medical Act." Carried.

4. Reports of Standing Committees and Their Consideration

A. Executive Committee

The Registrar advised there had been two meetings of the Executive Committee held since the October meeting of Council, mimeographed copies of which had been forwarded to each member of Council.

Motion: "THAT the minutes of the two Executive Committee meetings held Nov. 29, 1949, and March 3, 1950, be accepted as having been read." Carried.

Business Arising from Minutes of the Executive Committee Meetings

(a) **Representative From the Constituency of Souris.**

The President advised that Dr. Wm. Malyska, of Deloraine had been elected representative from the Constituency of Souris by casting vote of the Registrar.

(b) **Reciprocal Relations With Other Medical Boards**

The Registrar said he had nothing further to report on negotiations with other medical boards for reciprocal registration.

(c) **General Medical Council of Great Britain Certificates.**

The Registrar advised he still had not received reply to his letters of Nov. 21, 1949, and Feb. 8, 1950, inquiring whether the General Medical Council requires the certificate issued to registrants of this College who wish to become registered in Great Britain.

(d) **Result of By-Election in Constituency of Portage la Prairie.**

The President reported that Dr. G. P. Armstrong had been elected by acclamation to the Council as representative of the constituency of Portage la Prairie, in the recent by-election.

Election Statistics:

For information the Registrar advised there were 14 physicians in the constituency of Portage la Prairie, 11 of whom were eligible to vote or be elected to the Council. Six Nomination Papers were returned, three members were nominated, two of whom did not accept nomination.

Disposal of Nomination and Voting Papers.

Motion: "THAT the nominating and voting papers be destroyed." Carried.

(e) **Appointment of Member to Replace Dr. A. A. Alford on Education Committee.**

Motion: "THAT Dr. B. D. Best be a member and chairman of the Education Committee." Carried.

(f) **Appointment of Member to Replace Dr. A. A. Alford on Discipline Committee.**

Motion: "THAT Dr. G. P. Armstrong be a member and chairman of the Discipline Committee." Carried.

(g) **Appointment of Member to Replace Dr. A. A. Alford on Liaison Committee.**

Motion: "THAT the Liaison Committee stand with the present members, and carry on until the October meeting of Council." Carried.

(h) **Registrars' Meeting in Halifax in June:**

The Registrar reported a letter had been received from Dr. H. L. Scammell, Registrar, Provincial Medical Board of Nova Scotia, advising that a meeting of the Registrars would be held in conjunction with the meeting of the C.M.A., and requesting suggestions as to subjects for discussion on the program.

Motion: "THAT the Registrar be sent to Halifax with expenses paid by the College." Carried.

The following suggested topics were discussed:

1. What are the other provinces doing about temporary licensure?

2. What are the other provinces doing in connection with issuing permits to Displaced Persons?

3. Uniform fees for licensing in Canada. Should a physician be required to register in each Province in which he practises, or should there be one registration with annual fee paid to the Province in which the physician is practising at the beginning of the year?

4. Do other provinces with reciprocity with Great Britain issue Enabling Certificates to U.S.A., Chinese or European graduates, thus enabling them registration in Great Britain in a round-about-way?

(i) **Unlicensed Physicians in Manitoba.**

The Registrar advised that the Registration Committe had under consideration the number of unlicenced doctors employed by the D.V.A. and permanent armed forces, stationed in Manitoba. He cited, as one of the problems in enforcing the Medical Act, the case of a doctor from Great Britain who interned in one of the local hospitals

when he might have availed himself of a temporary licence, went to assist a physician in a country practice without being registered, then left the province.

Dr. ..... thought something should be done to put strength into the regulations, so the Registration Committee could enforce them.

Dr. ..... pointed out that all medical fees for private work collected by the medical officer at Churchill are made payable to the Receiver-General of Canada, and suggested the Dominion Government should pay the registration fee of physicians in this category.

Dr. Macfarland said this question was discussed at the Registrars' meeting last year. The Registrar in Saskatchewan sent a letter to the Dominion Government with the usual response. He said the Registration Committee were considering a suggestion that a registered letter be sent to the individual concerned, with a copy to the Department of National Defence, Department of National Health and Welfare, and Department of Veterans Affairs at Ottawa.

Dr. Williams said an officer in the R.C.A.M.C. receives a rate of pay above that of the normal rank, because he is a medical officer. Since they receive a higher rate of pay, they should pay their registration fee.

Motion: "THAT the Registrar take this question up at the meeting of the Registrars in June, and that the matter be tabled until the October meeting for direction." Carried.

(j) **Complaint Re** .....

The Registrar was instructed to refer this matter to the Executive Committee.

(k) **Foreign Credentials.**

The Registrar explained that the Registration Committee felt in one case, that the applicant, Dr. A. Wasilewski, had sufficient training to receive registration without further examination if there was power under the Medical Act. The solicitor's opinion was that applicants whose qualifications were obtained outside the British Commonwealth of nations must either meet the requirements of the University of Manitoba for a graduate in medicine, or produce to the Registrar a certificate under the corporate seal of the University of Manitoba that the Senate of the University has been satisfied that the applicant is by way of medical education and otherwise a proper person to be registered. The Registration Committee recommended that the applicant complete six months interneship, to improve his knowledge of English, after which he could write the examination of the Medical Council of Canada. The doctor is now doing an interneship at the Grey Nuns Hospital, Regina.

B. Registration Committee

The Registrar advised there had been five meetings of the Registration Committee held since the October meeting of Council, and mimeographed copies of the minutes had been forwarded to each member of Council. He pointed out the case of one applicant, Dr. L. Kulczycki, who was a naturalized British subject, graduate of the Polish School of Medicine, Edinburgh, and registered on the Foreign List of the General Medical Council of Great Britain. The Registration Committee passed this on reciprocity, but the regulations laid down by the by-laws state that the applicant must be registered on the British Register by virtue of being a graduate from a British university.

Motion: "THAT the minutes of the Registration Committee meetings be accepted as having been read." Carried.

C. Education Committee

The question of Basic Licence and Specialist Register were referred to the Education Committee for study and report.

D. Finance Committee

No special report—refer to Treasurer's Report

E. Legislation Committee

1. Dr. Poole advised that as Chairman of the Legislation Committee he had sat in at a meeting of the Committee of Fifteen. He explained that in the dying hours of the session of the Legislature an Amendment to the Workmen's Compensation Act had been presented to allow Osteopaths and Chiropractors to treat injured persons. He said a letter had been sent by the Manitoba Medical Asosciation protesting the short notice of this amendment, but that it had gone through.

The Registrar advised that mimeographed copies of the minutes of the meeting of the Legislation Committee held Jan. 10, 1950, had been forwarded to each member of Council.

Motion: "THAT the minutes of the Legislation Committee meeting held Jan. 10, 1950, be accepted as having been read." Carried.

2. In connection with the size of Council, Dr. Poole said he could see that members might be asked to serve on nearly every committee if the number of members was cut down. He thought the method of election should be under some other system, either judicial divisions, or better still, the province should be divided into medical divisions. He pointed out that over half the medical population in the province lived in South Winnipeg. He asked for an expression of opinion as to whether the Council should be reduced in size.

Dr. ..... considered the size should be reduced from a financial point of view.

Dr. ..... said if the Council was reduced by four members $100.00 would be saved plus travel expenses, against that the members would be doing extra committee work, which also costs money,

and men having too much to do cuts down on efficiency.

Dr. ..... suggested if the Council was reduced pro rata city and country, there would be committees requiring the attendance of members coming in from distant points.

Dr. ..... pointed out during the past two or three years personnel of committees had to be changed many times because rural members could not get in. He though the matter required a great deal of study.

The President asked for a show of hands whether the number of members of Council should be reduced. Two to one were opposed to any reduction. The question was referred back to the Legislative Committee re method of election.

F. Library Committee

Dr. Best advised that the Medical Library was in a perilous state financially, and was requesting an additional grant over and above the $750.00 annual grant. He said that the prices of books and journals had increased and quoted the following figures compiled by the Librarian:

The binding since 1939 has risen from $2.50 a volume to $4.00, or $6.80 according to size and style of binding. On top of this price is the 8% sales tax. The journal subscriptions have all increased alarmingly during the last 18 months, as for example, the American Medical Association Journals from $121.20 in 1948 to $144.20 in 1950. The Williams & Wilkins journals we subscribe to have increased from $116.00 to $136.95 in 1950. Books too have shown a sharp rise in prices, $15.00 is quite usual for American books.

Dr. Best pointed out the relevant sections of the Medical Act. Section 16 (1) limits the amount of grant to seven hundred and fifty dollars per annum for the maintenance and care of the library. Section 16 (2) gives the Council power to fix a fee to be charged and collected from each member of the college, resident in Winnipeg, and applying for the privileges of the library (the fee not to exceed twenty dollars per annum). Section 91 (2) gives the council power to expend moneys for encouraging interest in and knowledge of medical and surgical science and practice, and for purposes deemed to be for the general advantage of the medical profession and the members of the college. Dr. Best stated that the amount of $750.00 was definitely stated in Section 16 (1), and he did not think 16 (2) would be very popular, and inquired whether Section 91 (2) could be interpreted so that the grant to the library could be increased.

After considerable discussion the following motion was passed.

Motion: "THAT the grant to the Library be increased by Four Hundred Dollars ($400.00), subject to advice of our legal advisor." Carried.

Department of Health and Public Welfare

Comparisons Communicable Diseases — Manitoba (Whites and Indians)

DISEASES	1950 May 21 to June 17,'50	1950 Apr. 23 to May 20,'50	1949 May 22 to June 18,'49	1949 Apr. 24 to May 21,'49	Total Jan. 1 to June 17,'50	Total Jan. 2 to June 19,'49
Anterior Poliomyelitis	0	1	6	1	3	16
Chickenpox	85	100	142	116	777	799
Diphtheria	0	1	0	0	5	12
Diphtheria Carriers	0	0	0	0	0	2
Dysentery—Amoebic	0	0	0	0	1	0
Dysentery—Bacillary	2	4	4	0	19	8
Erysipelas	1	4	2	1	28	17
Encephalitis	0	0	0	0	0	0
Influenza	12	22	12	22	97	167
Measles	178	220	1106	814	939	4572
Measles—German	12	4	34	40	18	87
Meningococcal Meningitis	0	0	2	4	7	15
Mumps	33	20	79	81	191	836
Ophthalmia Neonatorum	0	0	0	0	0	0
Pneumonia—Lobar	16	21	11	18	106	128
Puerperal Fever	0	0	1	1	2	3
Scarlet Fever	7	8	8	6	182	56
Septic Sore Throat	4	0	4	4	20	24
Smallpox	0	0	0	0	0	0
Tetanus	0	0	0	0	1	1
Trachoma	0	0	0	0	0	0
Tuberculosis	55	52	205	103	367	547
Typhoid Fever	1	0	0	1	1	5
Typhoid Paratyphoid	0	0	0	0	0	0
Typhoid Carriers	1	0	1	0	2	2
Undulant Fever	1	1	2	0	11	8
Whooping Cough	8	15	25	16	89	125
Gonorrhoea	76	55	78	128	488	608
Syphilis	12	24	32	29	114	205
Diarrhoea and Enteritis, under 1 yr.	5	9	20	24	54	109

Four-Week Period May 21st to June 17th, 1950

DISEASES (White Cases Only) *Approximate population.	*779,000 Manitoba	*861,000 Saskatchewan	*3,825,000 Ontario	*2,952,000 Minnesota
Anterior Poliomyelitis	—	—	5	7
Chickenpox	85	44	1093	—
Diarrhoea and Enteritis	5	—	—	—
Diphtheria	—	—	1	3
Dysentery—Amoebic	—	—	—	.5
Dysentery—Bacillary	2	—	1	2
Encephalitis	—	1	1	2
Erysipelas	1	—	2	—
Influenza	12	—	16	19
Infectious Jaundice	—	—	6	—
Measles	178	84	2535	968
Measles, German	12	411	5218	—
Meningitis Meningococcal	—	1	10	8
Mumps	33	294	1415	—
Pneumonia Lobar	16	—	—	—
Scarlet Fever	7	23	128	33
Septic Sore Throat	4	3	7	13
Tuberculosis	53	43	80	112
Typhoid Fever	1	1	2	1
Typhoid Para-Typhoid	—	—	1	—
Typhoid Carrier	1	—	1	—
Undulant Fever	1	—	6	22
Whooping Cough	8	15	190	132
Gonorrhoea	76	—	153	—
Syphilis	12	—	80	—

DEATHS FROM REPORTABLE DISEASES

For the Month of June, 1950

Urban—Cancer, 47; Influenza, 1; Pneumonia Lobar (108, 107, 109), 2; Pneumonia (other forms), 4; Syphilis, 1; Tuberculosis, 3; Neoplasms of Lymphatic and haematopoietic tissues, 5; Benign neoplasm of brain and parts of nervous system, 1. Other deaths under 1 year, 22. Other deaths over 1 year, 196. Stillbirths, 15. Total, 233.

Rural — Cancer, 32; Influenza, 1; Measles, 1; Pneumonia Lobar (108, 107, 109), 4; Pneumonia (other forms), 14; Syphilis, 1; Tuberculosis, 8; Neoplasms of Lymphatic and haematopoietic tissues, 1; Diarrhoea and Enteritis under 2 years, 3; Diarrhoea of newborn, 2. Other deaths under 1 year, 21. Other deaths over 1 year, 193. Stillbirths, 16. Total, 230.

Indians—Cancer, 1; Influenza, 1; Pneumonia other forms), 2; Tuberculosis, 1; Whooping Cough, 3. Other deaths under 1 year, 3. Other deaths over 1 year, 7. Total, 10.

♦

The continued low incidence of communicable diseases in Manitoba is a source of satisfaction to the Department and the Medical Profession. There has been no evidence so far this year of any epidemic, in spite of flood emergency and unusual weather conditions. The fact that diphtheria, whooping cough, and typhoid fever (diseases for which specific preventive measures are available) are at an all time low, reflects favorably on the co-operation of all physicians.

We would, however, draw attention to the fact that the incidence of dysentery and scarlet fever is higher than last year. Scarlet fever has been reported in each month and the total cases to date are over three times in excess of the similar period in 1949. Most cases continue to be of a mild nature but physicians should be aware that the infection is endemic and be on the lookout for its manifestation.

MEDICAL LIBRARY

The University of Manitoba, Faculty of Medicine

Recent Accessions, 1948-49

General List

Myers, J. A. The chest and the heart; Section 1, the Chest, ed. by J. A. Myers and Section 2, the Heart, ed. by C. A. McKinley.
Thomas, c1948. 2 vol.

Nesbit, R. M. Fundamentals of urology. 3d ed. rev.
Edwards, 1948. 130 p.

Nesbit, R. M. Problems in urologic diagnosis. Series 1.
Edwards, c1948. 97 p.

Netter, F. H. The Ciba Collection of medical illustrations; a compilation of pathological and anatomical paintings.
Ciba Co. Ltd., c1948. 222 p.

Newburgh, L. H. Some fundamental principles of metabolism, by L. H. Newburgh, M. W. Johnston and J. D. Newburgh. 3d rev. ed.
Edwards, 1948. 70 p.

Papanicolaou, G. N. The epithelia of woman's reproductive organs; a correlative study of cyclic changes, by G. N. Papanicolaou, H. F. Traut and A. A. Marchetti.
Commonwealth Fund, 1948. 53 p.

Péhu, Maurice. L'acrodynie infantile, par Maurice Péhu et Jean Boucomont.
Masson, 1944. 98 p.

The Practitioner. The National Health Service Act in Great Britain; a review of the first year's working.
The Practitioner, 1949. 110 p.

Rigler, L. G. The Chest; a handbook of roentgen diagnosis.
Chicago, Year Book, 1946. 352 p.

Rivers, T. M. Viral and rickettsial infections of man . . .
Lippincott, 1948. 587 p.

Rows, R. G. Epilepsy; a functional mental illness; its treatment, by R. G. Rows and W. E. Bond.
Lewis, 1926. 138 p.

Scherf, David. Cardiovascular diseases, by David Scherf and L. J. Boyd . . .
Lippincott, c 1947. 478 p.

Sheldon, W. H. Psychology and the Promethean Will.
Harper, c 1936. 265 p.

Sherman, H. C. Chemistry of food and nutrition. 7th ed.
Macmillan, 1947. 675 p.

Spivack, J. L. The surgical technic of abdominal operations. 3d ed. rev.
Debour, 1940. 743 p.

Sturgis, C. C. Hematology.
Thomas, c 1948. 915 p.

Tauber, Henry. The chemistry and technology of enzymes.
Wiley, c1949. 550 p.

Templeton, F. E. X-ray Examination of the stomach . . .
Univ. of Chicago Press, c1944. 516 p.

Thomas, H. E. A study of leprosy colony policies . . .
American Mission to Lepers, 1947. 99 p.

Treasury of Human Inheritance, ed. by R. A. Fisher.
London, Cambridge, 1934-47. v. 4. Contents: Nervous diseases and muscular dystrophies, by Julia Bell. Pt. 1, Huntington's chorea. Pt. 2, On the peroneal type of progressive muscular atrophy. Pt. 3, On hereditary ataxia and spastic paraplegia. Pt. 4, On pseudo hypertrophic and allied types of progressive muscular dystrophy. Pt. 5, Dystrophia myotonica and allied diseases.

Treves, Sir Frederick. Surgical applied anatomy. 11th ed. rev. by Lambert Rogers . . .
Cassell, 1947. 560 p.

Todd, J. C. Clinical diagnosis by laboratory methods; a working manual of clinical pathology, by J. C. Todd and A. H. Sanford with the collaboration of G. G. Stilwell. 11th ed.
Saunders, 1948. 954 p.

Tredgold, A. F. A text-book of mental deficiency (amentia). 7th ed. rev.
Baillière, 1947.

Trelease, S. F. The scientific paper; how to prepare it, how to write it. A handbook for students and research workers in all branches of science.
Williams, 1947. 152 p.

Truex, R. C. Detailed atlas of the head and neck, by R. C. Truex and C. E. Kellner.
Oxford Univ. Press, 1948. 162 p.

Turner, C. D. General endocrinology.
Saunders, 1948. 604 p.

Watkins, A. L. Physical medicine in general practice.
Lippincott, c1946. 341 p.

Kopetsky, S. J. The surgery of the ear . . . 2d ed.
Rebman, c1908. 364 p.

Williams, R. R. Vitamin B_1 (thiamin) and it's use in medicine, by R. R. Williams and T. D. Spies.
Macmillan, c1938. 411 p.

Wilson, E. B. The cell in development and heredity. 3d ed. with corrections.
Macmillan, c1925. 1232 p.

Winton, F. R. Human physiology, by F. R. Winton and L. E. Bayliss. 3d ed.
Churchill, 1948. 592 p.

Young, B. R. The skull, sinuses and mastoids; a handbook of roentgen diagnosis.
Year Book, c1948. 328 p.

Young, James. A text-book of gynaecology for students and practitioners. 7th ed. rev.
Black, 1947.

Directory

Names and Phone Numbers of

Detailmen

Representing Review Advertisers in this issue, whose names are not listed under a business address.

Abbott Laboratories
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X-ray & Radium Industries Ltd.
J. E. Bradley 97 862
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Book Review

Histology: If by any chance you feel the need or desire of reading up on the minute structure of organs or tissues, A. W. Ham's new book is the one to buy. It contains everything about histology including the histology of everyday practice. It it highly readable. The illustrations are numerous, large, clearly labelled and very helpful. This is not the ordinary class-room text book which limits itself to normal tissues. It also integrates a good deal of physiology, of pathology and of clinical medicine. It thus serves the student as an introduction to later studies and also impresses upon him the practical importance of histology—a fact which is likely to make the subject more interesting and its study more profitable.

For graduate readers there is an extensive bibliography which will be of value when special problems are being considered. The histology of oedema, heart disease, cancer, arthritis, etc., is an unusual yet logical inclusion which makes the work more valuable to readers at all stages of study.

We all of us regret that we have forgotten so much of what we once knew, and sometimes we turn to the texts we used as students. Nothing like this book existed when we were students. Actually it is not only profitable reading but pleasurable also.

Histology by Arthur Worth Ham, M.B., Professor of Anatomy, in charge of Histology in the Faculties of Medicine and Dentistry, University of Toronto, Toronto, Canada. 756 pages, 445 illustrations including 4 plates in color. Publishers J. B. Lippincott Co., Montreal. Price $10.00.

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